

Part II

Title V MCH Block Grant Submission

Comprehensive Needs Assessment

Maternal and Child Health Population

New Mexico, July 8, 2005



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SECTION II: NEEDS ASSESSMENT, NEW MEXICO

II.B Five Year Needs Assessment

Five Year Process: Every five years this is a planned event with training workshops, design sessions and a work plan. It is a point of taking stock on a grand scale. Data and information are amassed. While the national and state indicators used are well known to all – the information is possibly unique to the state. Information came from Bill Analysis done in past five years on such topics as obesity and children, high risk prenatal care, or state needs for recruiting and retaining health professionals. The MCH program managers and staff, including WIC, Families FIRST and Family Planning, all participate in national, regional, state and local task forces and advisory committees. These are the source of ongoing discussion of needs and capacity issues, and serve to inform not only the needs assessment process but also the state planning process for Title V MCH. The NM Title V Program resides in a Department of Health that has its own strategic planning process that is data driven – but must incorporate the needs of all New Mexicans of all ages, across all Divisions of the Department.

Ongoing Process: The Title V MCH Program has ongoing input from several surveillance programs (PRAMS, YRRS, BRFSS and the national surveys CSHCN and NSCH), as well as a few evaluation studies (that emerge from asking the question – where are we on this indicator?); participation in several working groups that seek to improve access to care for the MCH population.

Cycle from analysis to examining capacity, to priorities: This is an ongoing process in NM; data come in at different times and are pressed into action by Title V MCH leadership and others. In the 5-year assessment process this year, data was available at the beginning and at the end – it was used to explore needs and capacity issues; and the final data products were confirmatory to the process. The Title V MCH program identified ten priority areas early in the process; these priorities were the product of working across the state with many groups and resulted in state negotiated performance measures.

Set annual targets: Targets were set using two processes: 1) knowledge of the extent of the need and a reasonable estimate of resources that could be brought to bear; and 2) trend analysis for selected measures such as teen births. Locally, activities were identified that addressed the priorities and allocation of resources for children's programming was identified across all state

agencies as well as within Title V. Resources were reviewed and new resources needed were also identified for special initiatives that addressed the priorities.

II.B.1 Process for Conducting the Needs Assessment

II.B.1.1 Description of State's Needs Assessment Methodology

The Needs Assessment Team: The team that assessed needs and resources for MCH was comprised of the Family Health Bureau Chief, the Medical Director, Program Managers for MCH Epidemiology, Family Planning, the Maternal, Child, Adolescent and Family Health (MCAF) Section, Children's Medical Services (CMS), Abstinence and program staff, including epidemiologists, the Maternal Health Program manager and the Child Health Program manager (see list of the working teams in the appendix). This report uses the term "Team" to refer to these people. Two consultants were hired to support the needs assessment process.

Assessment Planning and Time Frame: The formal outreach assessment work began in a workshop October 12-13, 2004 and continued through June 30, 2005. Susan Nalder and Jane Peacock lead this effort, using many materials provided in the Title V MCH training workshop for assessment held in St. Louis, as well as the MCHB Guidance. Every member of the team received a copy of the Guidance. The workshop was used to orient all staff to the Block Grant requirements of the assessment, to provide training and working tools, and to conduct exercises. The latter were adapted from the Title V MCH Assessment Training materials; a Q-Sort process was done. Staff of the FHB tends to not engage exercises such as the Q-sort in preference for discussions of real issues. Most staff were familiar with parts of the Block Grant process; there were a few new staff.

Development of the Methodology: This process began with a review of the population groups (mothers, infants, children and CYSHCN) and the pyramid; the Title V MCH conceptual framework that depicts the relationship across these dimensions and the indicators; data for all measures and indicators, and a discussion about issues. The team endorsed a focused process rather than a wide-ranging assessment of all dimensions of health and well being of this population. Resources are more and more limited and there is a need to define limits around what the NM Block Grant programs and partners actually work on or need to work on.

Key Products for the Needs Assessment as well as the Grant Application and Report:

1. REVIEW OF ALL NATIONAL AND STATE PERFORMANCE MEASURES, HEALTH SYSTEMS CAPACITY MEASURES, HEALTH STATUS INDICATORS, AND HEALTH OUTCOME MEASURES BY CRITICAL REVIEW CRITERIA AND RELATED TOOLS FOR PREPARING THE 2005 SUBMISSION

The MCH Epidemiologist developed the following tools:

- A summary document for each set of Title V indicators, showing up to 10 years of data, with information about the numerator, the denominator and the data source(s) in MS Excel format. This tool will continue in future years, making data collection tasks easier.
- A work plan based on Title V Guidance for every section of the assessment, application and report (actual text was pasted from the Title V MCH Block Grant Guidance pdf document) in table format, showing maximum characters for writing. The worksheet was in table format so writing assignments could be recorded. Staff found this exceptionally helpful.
- An outline for each section of the assessment, application and report showing total character count, so staff could easily write and the document would be more easily compiled from several writers.
- A recommended approach to evaluating the state's performance on every indicator that was adopted as format for writing the assessment by the team:
 - Status, trends, gaps & disparities
 - Risk factors or positive influence factors (strengths, capacity) that contribute to performance on the indicator
 - Healthy People 2010 objective;
 - State targets;
 - Identification of evidence-based policies; evidence-based programs, effective strategies
 - Identification of data-information sources.

Each member of the team took responsibility for doing a work-up on the measures based on the criteria listed above. Program staff consulted other Bureaus and programs of the Public Health Division and other divisions of the Department of Health, other state agencies, and other MCH partner organizations and coalitions as relevant to the measure being reviewed. Several programs drew on results of focus groups and other assessment processes conducted recently with

providers and clients. Written reports on each measure were given to the MCH Epidemiologist for review and refinement.

2. IDENTIFICATION OF TEN PRIORITY MCH TOPICS FOR THE ASSESSMENT AND FOR THE FIVE-YEAR FUNDING CYCLE 2006-2010.

Beginning at the workshop in October 2004 and continuing through March 2005, FHB staff worked at the first steps in setting priorities for the assessment, and for the coming five-year grant period. The list comprised input gleaned by FHB staff over the past five years through their work with DOH, other agencies, communities, advisory groups and other ongoing contacts. It comprised:

- Immigrants and MCH
- Access to and Use of Health Care, Health Insurance, and Other Coverage
- Transition for Youth with Special Health Care Needs
- Preconception and Prenatal Health
- Male Involvement and Fatherhood
- Obesity
- Teen Births (ages 15-17) and Chlamydia
- Violence
- Unintentional Injury
- Positive Youth Development

3. COMPILATION OF A NEW MEXICO MCH DATA BOOK TO BE USED FOR THE ASSESSMENT EXERCISE IN THE FOUR PUBLIC HEALTH DISTRICTS

The MCH Epidemiologist took the lead in conceptualizing and organizing a “New Mexico Maternal Child Health Data Book” It was modeled in part from the MCH Data book from the Title V MCH Program in Alaska. Data was researched and graphs prepared; a literature review conducted for new topics (Immigrants and MCH, Male Involvement and Fatherhood). Program managers, epidemiologists and other staff contributed material, including material taken from the performance measure reviews described above. The NM MCH Data book, Preliminary Report 2005, will be available in September 2005. It was developed as a preliminary report, using contracted services to develop the data graphs; and unfortunately several critical errors were discovered. These books with errata sheets were given to all participants in the district MCH

Needs Assessment workshops as a reference and base for discussion around the priority topics/indicators.

4. DEVELOPMENT AND IMPLEMENTATION OF A SERIES OF MCH ASSESSMENT CONSULTATION-WORKSHOPS TO OBTAIN INPUT AND INFORMATION FROM STAFF AND COMMUNITY PARTNERS ACROSS THE FOUR PUBLIC HEALTH DIVISION DISTRICTS

The core team selected 10 priority topics for review and discussion at the four district MCH Needs Assessment workshops and developed the facilitated discussion outline for these topics (listed in previous section).

The Family Health Bureau Chief and MCH Epidemiologist were given the responsibility to present an overview of the history of the Title V Program, the MCH Block Grant, the MCH needs assessment process, and review of relevant indicators and data in preparation for discussion of the ten topics described above. Notebooks were assembled for each participant with workshop agenda, copies of PowerPoint presentations, worksheets, and the draft MCH Data Book. The Public Health Division leadership in each of the districts was contacted and the purpose of the workshop explained. District staff were asked to invite public health staff and community partners involved in MCH programs and services from throughout the district, consumers of MCH services, and other local leaders knowledgeable about community needs to attend the workshop. The workshop agenda was sent to each district. Family Health Bureau (FHB) staff traveled to each of the four Public Health Districts to conduct a one-day Maternal and Child Health (MCH) needs assessment workshop. Staff from the FHB included the Bureau Chief, Medical Director and Program Managers and/or staff for Children's Medical Services, Families FIRST, Family Planning, MCH Epidemiology, Maternal Health, Adolescent Health, and the Abstinence Education Program.

A total of 157 people participated in the four MCH District Needs Assessment Workshops (duplicate count for those FHB staff and consultants who attended more than one of the workshops). Attendance is given below by district, indicating the total number attending; number of NM Department of Health staff representing the district management team, health promotion, CMS, Families First, and local public health office staff working in CMS, Families

FIRST, the Family Planning Program, and the WIC Program; number of community representatives including schools and school based health centers, university-based MCH services, community health councils, Maternal Child Health councils, foundations, local maternal child health service providers, community health centers, county government, New Mexico Teen Pregnancy Coalition, Border Health Education Center, Head Start, March of Dimes; Family Health Bureau staff; and the two consultants.

District 1: 39 (18 district/local NM Department of Health staff; 9 community members; 10 Family Health Bureau staff; 2 consultants)

District 2: 44 (22 district/local NM Department of Health staff; 5 community members; 15 Family Health Bureau staff; 2 consultants)

District 3: 38 (8 district/local NM Department of Health staff; 17 community members; 11 Family Health Bureau staff; 2 consultants)

District 4: 36 (16 district/local NM Department of Health staff; 8 community members; 10 Family Health Bureau staff; 2 consultants)

The FHB Chief gave an overview of the Title V MCH Block Grant. It covered the definition and history of Title V and the Block Grant, MCH strategic goals, community-based services supported by Title V, funding and the major MCH programs, the pyramid of services (direct, enabling, population-based, and capacity-building), and the FHB organizational structure. The FHB's MCH Epidemiologist reviewed the needs assessment process and introduced participants to the new NM Maternal and Child Health Data Book (provisional March 2005). She gave special attention to information and data on the 10 priority topics. At each District workshop, participants divided into working groups on each of the ten priority topics. Staff for the FHB facilitated and recorded the working groups to free-up local participants for contributing to the discussions. The agenda for the working groups included identifying the three most important current activities, other current activities, the three most important recommendations, and other recommendations. As time permitted, participants also identified community strengths and resources and constraints to addressing needs.

Each workshop also had an open session to allow participants to identify other issues and needs from their communities or the district that had not been addressed in the 10 working groups. At the end of each workshop a verbal evaluation of “what was good” and “what could be improved” was conducted and recorded in writing. Following completion of the four district needs assessment workshops, a written report documenting the current activities (including the three most important), recommendations (including the three most important), constraints, community strengths and resources, other issues identified, the listing of “what was good” and “what could be improved,” and the workshop participant list were sent to district public health leaders and Family Health Bureau program staff who had participated in the workshops for review and comment to assure as accurate a recording as possible.

5. ANALYSIS AND SYNTHESIS OF MCH DISTRICT NEEDS ASSESSMENT WORKSHOP CAPACITY INFORMATION AND RECOMMENDATIONS

A format was developed by the MCH Epidemiologist and consultants for categorizing the current capacity for each of the ten priority topics discussed at each MCH District Needs Assessment workshop. For each priority topic each activity/service identified was categorized by district and pyramid level (direct service; enabling service; infrastructure-building service; population-based service) using the definitions found in the Title V MCH Block Grant application guidance. Each activity/service was also classified by population group served (pregnant women and mothers; infant, child, teen, children and youth with special health care needs, male, and “all population” groups). The capacity listing by these categories was then put into an Excel table. A second Excel table was then developed for each priority topic showing capacity by the number of services (any given service could impact multiple population groups) provided to each population group, by pyramid level and district. A format was also developed by the MCH Epidemiologist and consultants for categorizing the recommendations for each priority topic from the MCH District Needs Assessment workshops. Each recommendation was categorized by district, pyramid level and population group impacted. An Excel table listing recommendations by pyramid level and district was developed. A second Excel table was then prepared for each priority topic showing the number of recommendations impacting each population group by pyramid level and district. As with capacity each recommendation could impact multiple population groups. A synthesis document was developed with a narrative

summary for each priority topic of capacity, recommendations, constraints, and community strengths and resources with reference to the tables described above. A summary of other issues identified by each of the districts at the conclusion of each MCH District Needs Assessment workshop was also prepared.

NOTE PLEASE: The report of the MCH District Needs Assessment findings and recommendations is found as the last section of the NM Needs Assessment Document.

II.B.1.2 Formal & Informal Collaboration Processes

Collaboration processes for the assessment took place both formally and informally through out the year and during the specific assessment workshops. Please see collaboration description below in II.B.2

II.B.1.3 Quantitative & Qualitative Methods Used to Assess Needs of MCH Populations

The perspective of the Title V MCH Program – with leadership from the MCH Epidemiology Program - is that qualitative and quantitative assessment methods form a continuum in data and information. Data collection ranges from the more open-ended to the more closed-ended. This diagram is not inclusive; but gives examples:

Qualitative.....//.....				Quantitative
Participant	Document	Focus	Structured	Survey
Observation	Review	Groups	Interview	Questionnaire

Key constructs: In qualitative methods the researcher does not presume to know what is in and on people’s minds (Michael Patton, 1980) while in quantitative methods the researcher does presume to be knowledgeable about these things (MCH) and seeks to find out how much, how often and when events occur, and to whom. What is learned in observation, document review or focus groups can be used to develop interview forms or surveys; and what is learned in a survey often results in doing a focus group to understand why things are. Both methods are used in the Title V MCH assessment, and in the ongoing work of surveillance, epidemiology and evaluation.

DATA SYSTEMS USED TO MONITOR AND ASSESS

THE HEALTH OF MOTHERS AND CHILDREN IN NEW MEXICO

Vital Statistics	Population-Based Data Systems and Surveys	Hospital Discharge Data Systems	Pop-Based Disease Reporting & Case Finding	Client-based and other sentinel surveillance
<p>Birth registration, data on maternal & infant health</p> <p>Death registration, data on MCH related mortality</p> <p>Fetal death reporting, data on maternal & fetal health</p> <p>Linked birth-Medicaid reports, data compares Medicaid to non-Medicaid population</p> <p>Pregnancy terminations, anonymous reporting, estimates prevalence</p>	<p>-Census, critical to rates for many MCH indicators</p> <p>-Current Population Survey (CPS) of Census, key source for poverty estimates and health insurance coverage</p> <p>-Pregnancy Risk Assessment Monitoring System (PRAMS) every year</p> <p>-NCHS-HRSA/MCHB Survey of Children with Special Health Care Needs, NM sample 751 (2001 then every 4 yrs)</p> <p>-NCHS-HRSA/MCHB Survey of Child Health, NM sample 1,848 (2003 then every 4 years)</p> <p>-Youth Risk Resiliency Survey (YRRS) – equivalent YRBS, every 2 years)</p> <p>-Behavioral Risk Factor Surveillance Survey (BRFSS), every year</p> <p>-National Immunization Survey using State & Local Area Integrated Telephone Survey (SLAITS), NM data</p>	<p>Hospital Inpatient Discharge Data (HIDD) of NM Health Policy Commission</p> <p>Hospital discharge data from Indian Health Service entities serving NM populations</p>	<p>National and State Notifiable Diseases system, reporting to DOH</p> <p>Includes:</p> <ul style="list-style-type: none"> -birth defects -firearm injury or death <p>STD/HIV/AIDS reporting to DOH</p> <p>NM Birth Defects Surveillance</p> <p>NM Newborn Genetic Screening</p> <p>NM Newborn Hearing Screening & Referral</p> <p>Children’s Chronic Condition Registry (on hold, resume if funded)</p> <p>NM Child Fatality Review (on hold, transfer to injury prevention unit)</p> <p>NM Maternal Mortality Review (on hold, resume if funded)</p> <p>Office of Medical Investigator at UNM, used for CFR and MMR, other injury deaths</p> <p>NM Traffic Safety, Transportation related injury and fatalities</p>	<p>INPHORM, the public health client data system, DOH</p> <p>NM Prenatal High Risk Fund, Title V MCH Funded</p> <p>Families FIRST Perinatal Case Management, DOH</p> <p>Healthier Kids Fund, CMS Program, DOH</p> <p>NM WIC Program Tribal WIC Programs</p> <p>Pregnancy Nutrition Surveillance System-CDC</p> <p>Pediatric Nutrition Surveillance System-CDC</p> <p>State Medicaid Program –family planning, pregnancy and children</p> <p>CYFD: data on child abuse reports, foster care, juvenile justice, other</p> <p>Other special studies done by programs</p>

❖ **Pregnant women, mothers and infants**

Quantitative: Descriptive analysis and reporting are the main methods used based on data from Vital Records, NM Pregnancy Risk Assessment Monitoring System, NM Medicaid, NM WIC and NM Hospital Inpatient Discharge Data (HIDD). Linked studies such as linked birth+death, linked birth+Medicaid have been done in previous years and when resources are in place, will continue. The Families FIRST Perinatal Case Management program collects data; it has not been analyzed for several years. In 1998, Families FIRST data was linked to the birth files to examine program impact; unfortunately program data was incomplete in key demographic fields so that a linked study could not be completed. NM PRAMS is the strongest source of data about pregnant women and infants; the program has produced data used in the DOH strategic plan, the NM Children's Cabinet Report Card and the Prenatal Care Taskforce. Within the past 5 years, more advanced studies were done by Ssu Weng, MD, MPH, using PRAMS data on prenatal access for immigrant women and a study of breast feeding duration:

Qualitative: Focus group – open ended needs assessment have been done with Navajo mothers to learn what their needs are for prenatal health; the CMS program conducts interview-discussions with various advisory groups concern with newborn hearing, youth in transition and family involvement in CSHCN.

GIS Descriptive: In 2005 the District I Epidemiologist worked with a team to develop detailed tables and mapping of several indicators for Albuquerque by Zip Code. These included several MCH indicators: births to teens age 15-19, births to women 20-44, low birth weight births to teens age 15-19, low birth weight to women 20-44, infant deaths, asthma cases from the former Children's Chronic Conditions Registry, asthma hospital discharges age 5-14, and Medicaid enrollees under age 19.

• **Children**

Quantitative: having the state sample of 1,848 NM children from the National Survey of Children's Health thrills NM. The main assessment approaches have been descriptive analysis of data from Vital Records, National Survey of Child Health (NSCH), NM Medicaid, NM WIC and NM HIDD.

Qualitative:

GIS Descriptive: In 2005 the District I Epidemiologist worked with a team to develop detailed tables and mapping of several indicators for Albuquerque by Zip Code. These included several

MCH indicators for children: deaths by age groups, asthma cases from the former Children's Chronic Conditions Registry, asthma hospital discharges age 5-14, and Medicaid enrollees under age 19.

- **Children & Youth with Special Health Care Needs**

Quantitative: Descriptive analysis and reporting are the main methods used based on data from the NM sample in the National Survey of Children with Special Health Care Needs, and from the 2003 NSCH. NM barely scratched the surface of this rich source of information; an endeavor that will continue into the coming year. The CMS program did have a Children's Chronic Conditions Registry (3CR) for many years that was designed to serve active clients in the program with such things as immunization reminders, and to use it to report estimates of CYSCHN in the state. Unfortunately the 3CR was not designed with surveillance in mind; as reported in the previous 5 year assessment, estimates produced from 3CR were very far out of range of National Health Interview Survey (NHIS) estimates for similar conditions. There were no case definitions used for 3CR; and no validation of diagnoses, and non-standard fields were created for basic demographic information. Evaluation of the database took place in 2004 where it was learned that the system design, in MS Access, actually assigned a new case number to children each time it was loaded up; duplicating and reduplicating them. Unfortunately after staff transferred out of the unit, the CMS program apparently could not continue funding of the effort, and could not fund bare minimum need positions to do this kind of work for NM (data manager-SAS programmer and epidemiologist).

Qualitative: CMS conducts ongoing needs assessment through its established advisory groups on topics of newborn hearing screening, newborn screening and youth in transition. The findings from these discussions are used to address client and agency needs.

Evaluation Studies: Tierney Murphy, MD, MPH, a CSTE-CDC MCH Epidemiology Fellow has evaluated the birth defects surveillance data collection methods and protocols towards improving the data base and the abstracting tools. She has also evaluated the newborn hearing screening data collection methods and protocols for identifying and following-up on infants who failed screening, towards recommending improvements in this system. The CMS program will need to strengthen its system for tracking newborns who failed screening or who were discharged from a hospital without screening.

II.B.1.4 Methods Used to Assess State Capacity by Pyramid Levels

The compilation and analysis all of the Title V MCH measures and indicators – and related indicators that come from surveillance systems like PRAMS, NSCH, BRFSS, YRRS - served as the center-piece for assessing our capacity by pyramid levels. The measures and indicators cut across health status, healthy & health risk behaviors, access to and use of primary preventive care – and, specialty care. All staff were asked to assess various indicators according the gaps and disparities – that brought to the foreground the needs for capacity in selected areas. The most significant gap in capacity concerns the needs of pregnant women, newborns and the 0-3 population; and children. While the evidence is clear that critical indicators were adopted as state performance measures – regarding the mental health and well being of mothers and infants, the state will need to work progressively over the coming years to put resources in place to address these needs. Such needs include evidence-based approaches to home visiting; evidence-based approaches to improving the quality of prenatal care and finding approaches to make it highly sought-after by high-risk mothers; evidence based approaches to serving the needs of parents of young children; and an increase in the population of young children and their families who have benefited from AAP standards of early periodic screening, diagnosis and treatment. There continues to be a “pagoda-shaped” budget that pays direct care for safety net services and enabling services in the NM Title V Block Grant; there are not sufficient funds at the base to build systems and evidence-based programs to address the critical needs for maternal, infant and child health. The Title V MCH program has made progress in strengthening its MCH epidemiology resources – not only for data collection and analysis, but also for policy analysis and the “data to action” dimensions that are so critical. There are no funds for selected needs such as birth defects, children with chronic conditions – that will not be addressed without additional funding.

II.B.1.5 Description of All Sources Used in Needs Assessment

Most Current Aggregate Reports, Title and Brief Description	Year Most Recent Report
Data request, specific to Title V Measures, births and mortality, NM Vital Records and Health Statistics (VRHS). 1990-2003 and 2004 provisional. Internal document in excel format	2004 provisional
Census estimates for NM, prepared by Bureau Business & Economic Research (BBER) of the University of NM – used for denominators	2003
NM Pregnancy Risk Assessment Monitoring System (PRAMS), 1997-2002, new data just weighted with some descriptive analysis for 2003; used extensively for maternal and infant assessment; used as proxy for findings of Medicaid and non-Medicaid mother and infant outcomes; used to develop state performance measures on healthy births, abuse in pregnancy and ongoing measure of intention of pregnancy and home visiting; county specific indicators.	1997-2002; plus 2003
Data request, specific to Title V Measures for infants and children enrolled in Medicaid and S-CHIP, received services, dental services, family planning waiver clients, aggregate counts in excel format	2003-04
Medicaid HCFA Form 416, report on children receiving EPSDT services, dental and other; the 2004 report had not yet been approved and released by NM Medicaid	2003
NM DOH Client data system for counts of prenatal, infant, child and family planning care; NM DOH High Risk Prenatal, NM DOH Healthy Kid Fund, CMS program counts	2004
NM WIC program, unduplicated counts of mothers, infants and children by race ethnicity	2004
National Survey of Children's Health, 2003: CDC/NCHS/SLAITS. Analysis performed using Stata Version 7, survey set commands from technical instructions on weights; for several indicators. We can't wait to do more with the data set! Thanks for this data.	2003
National Survey of Children with Special Health Care Needs, 2001; analysis done in previous years; valuable reference; used minimally this time	2001
Data for form 21 was downloaded from websites and obtained directly from WIC program, TANF, Food Stamps, Foster Care, Juvenile Justice, Dept Public Education	2003-2004
NM Behavioral Risk Factor Surveillance Survey (BRFSS) for selected measures on women's health, health of youth in transition age groups	2002-03
NM Youth Risk Resiliency Survey (YRRS), NM equivalent of YRBS but changed name because state obtains data on positive aspects of youth development and support; done every 2 years	2003
Primary Care Bureau/Health Systems, HPSA for mental, dental and primary care; urban-rural designations for counties.	2004
New Mexico Health Policy Commission; hospital discharge reporting, of limited value due to not having SAS programming capability to produce required reports. Quick Facts at www.hpc.nm.us.gov useful for health professional counts and related resources information.	2005
NM Traffic Safety Bureau, reporting on non-fatal motor vehicle crash data; 2003 still in progress	2002
Injury Report, Injury Epidemiology; 2004 data	2005
HSD Monthly Report on Eligibles and Recipients: Food Stamps, TANF, Medicaid, Medicare	Jan 2005
VRHS: Linked Birth-Death, most current 1999; summarized in needs assessment sections on infant mortality; next links to be done in 2005-2006.	1999
VRHS: Linked Birth+Medicaid, reported previous years	2000
VRHS, Annual Report, NM Vital Records & Health Statistics, 2003, invaluable for selected graphs and tables on birth and death population indicators	Spring 2005
County Health Profiles, NM Division of Epidemiology & Response, see at www.health.state.nm.us ; comprehensive compilation of all socio-demographic, health & health related data available at the county level in NM, most current year 2003 data	Ongoing

II.B.1.6 Strengths & Weaknesses of Needs Assessment Methods & Procedures

The DOH is a statewide agency with a long track record of working together as well as independently on all dimensions of a very large organization at work. The Public Health Division is noted for its systems thinking, often taking the lead in strategic planning and partnership building. Thus, while the Title V MCH Program has its comprehensive assessment mandate, there is exceptional access to the Divisions, Districts, Bureaus and Programs, and Local Health Offices. This framework is equally true for work across all entities – public and private – because NM is a state with great aspirations for the health and well-being of its population, and precious few resources to take on large goals.

The blueprint for this round of the comprehensive assessment was a strong one: Review the comprehensive assessment guidance, assemble data and information, review our status and determine what we needed to achieve. FHB staff who were new to the process received orientation, while others used the starting activities to renew familiarity with the various requirements. The single most difficult element, FHB staff with time to devote to the process and the product, was managed as best we could as all staff had a very full slate of program responsibilities. Contractors were identified to assist with the field work and to compile findings of the consultations held with each Public Health District and its MCH related partners, and were on-board early enough to benefit from the organizing workshops and meetings. FHB team members who participate in advisory groups, councils and the Children's Cabinet used these relationships to obtain input – formally, as with the CMS Newborn Screening Advisory Group, and less formally as with the Children's Cabinet, the EPSDT Advisory Committee, the Prenatal Care Network. The weak link in the chain was having a full-time coordinator-analyst to pull this all together; a new epidemiology position was created to do this work and will be in place by August or September 2005. Years of experience have taught us that this is “an inside job” and requires someone who is involved in the ongoing MCH work of the agency in its broadest construct.

In spite of having few staff, the assessment for 2005 has managed to cover the basic descriptive needs, including review of trends, gaps and disparities (where such data is easily available). Using univariate analysis, stratified analysis, multivariate analysis, statistical testing for

significance. The entire Title V MCH program staff joined in a review of our data and descriptive information, for each and every indicator. This was an education for all! They developed a report of known gaps, disparities, issues in addressing the indicator, best practices or evidence-based recommendations, and other information. The entire Title V MCH program staff

Weaknesses (limitations, constraints): The most significant limitation is staff time. The MCH Epidemiology Program Manager is the single source of data for the needs assessment serving as coordinator to obtain data and compiler to assess data, and write descriptive reports. This work is done while supervising the MCH Epi Program and providing data for other priority MCH needs. In 2005 there will be two new positions: 1) an epidemiologist assigned to the Title V MCH Block Grant and related MCH grants or projects, such as the ECCS; and 2) a senior MCH epidemiologist who will work full-time on epidemiology and evaluation projects. Other staff in the MCH Epidemiology Program work on PRAMS. CDC and CDC-CSTE assignees work on topics such as adequacy of newborn hearing screening, distribution of flu vaccines. While these staff members contribute to the Title V MCH assessment work, it is limited. Staff in Vital Records and Health Statistics produce aggregate reports according to Title V MCH data specifications.

II.B.2 Needs Assessment Partnership Building & Collaboration

New Mexico undertook a very collaborative process for the assessment using the Family Health Bureau Management Team as the lead collaborators. The Public Health Division leadership in each of the districts as well as District staff, public health staff and community partners involved in MCH programs and services from throughout the district, consumers of MCH services, and other local leaders knowledgeable about community needs were invited to the local community workshops. Family Health Bureau (FHB) staff involved included both Title V and Non-Title V Program Managers. They are all members of various advisory councils in the community and at the State level and so their knowledge of issues related to children is quite broad. Advisory Councils that were involved included the EPSDT Steering Committee, a group of key players in the delivery of EPSDT services. The Prenatal Care Taskforce also assessed the status of prenatal care during the year. The Teen Pregnancy Prevention Coalition and the Abstinence Education Program Manager analyzed the status of teen pregnancy in the state, creating new maps of the

prevalence across the state. The Emergency Contraceptive Working Group also played a key role. The FHB Management Team traveled to each of the four Public Health Districts to conduct the needs assessment workshops. Staff from the FHB included the Bureau Chief, Medical Director and Program Managers and/or staff for Children's Medical Services, Families FIRST, Family Planning, MCH Epidemiology, Maternal Health, Adolescent Health, and the Abstinence Education Program.

Attending the local workshops were a number of NM Department of Health staff representing the district management team, health promotion, CMS, Families First, and local public health office staff working in CMS, Families FIRST, the Family Planning Program, and the WIC Program; number of community representatives including schools and school based health centers, university-based MCH services, community health councils, Maternal Child Health councils, foundations, local maternal child health service providers, community health centers, county government, New Mexico Teen Pregnancy Coalition, Border Health Education Center, Head Start, March of Dimes; Family Health Bureau staff; and the two consultants. One of the consultants has also served on the New Mexico Public Health Association board as President. In addition, the Title V Program collaborated with many partners throughout the year to complete the 5 year assessment. With regard to children with special health care needs, the Children's Medical Services collaborated with the Newborn Hearing Screening Advisory Committee, the Newborn Genetic Screening Advisory Council and the Healthy Transition New Mexico Coordinating Committee to carry out an assessment of CYSHCN issues. And secondly, with regard to young children, the State has taken a very comprehensive approach to issues related to early childhood through the activities of the Early Childhood Comprehensive Systems Alignment grant. One related activity was an assessment of systems services for young children. This involved a large group of stakeholders (50 agencies) in early childhood area called the Early Childhood Action Network. This planning project has, after two years of work, resulted in a Comprehensive Strategic Plan for Early Childhood that includes twelve content areas including: an internal and external environmental scan, a vision and mission statement, five priority areas of focus, goals and objectives with timeframes for completion, a set of indicators to track early childhood outcomes; documentation of the strategic planning process with stakeholders, identification of best practice, evidence-based models; identification of key partners, linkages to

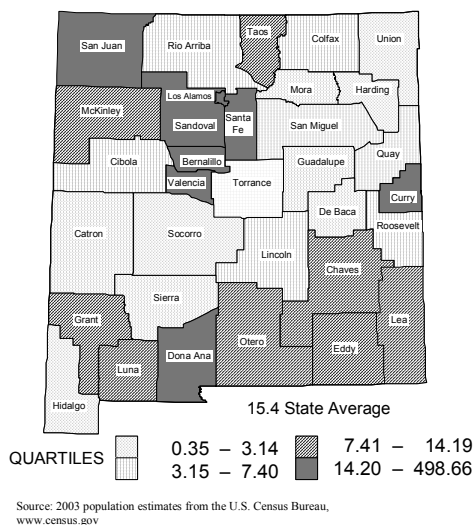
other State initiatives, evidence that the planning process is positioned to maximize the greatest policy impact; a sustainability plan for the follow up implementation phase, and strategies to strengthen data collection and make system improvements. The Children's Cabinet has supported this work. During the process, important relationships were formed across state agencies and between state agencies, the provider population and families. In addition, approximately 30 Division Directors and high-level managers and program experts across the Department of Health, Public Education Department, Human Services Department, Children, Youth and Families Department participated in an all day meeting to identify all early childhood programs, their funding levels over the previous 5 years and number of children served. The purpose for identifying data over the last five years is to establish baselines of funding levels and to determine if funding for children's services is increasing or decreasing in key early childhood component areas. This analysis has never been done before in New Mexico. The product of this effort is a worksheet summarizing all funds spent in the State of New Mexico for early childhood programming across all departments. The next steps in this analysis are to determine if total children's share of the budget is increasing or decreasing and if key components of the early childhood system are losing funding or gaining funding. This type of analysis leads policy makers to consider the whole MCH system and will lead to better alignment of policy decisions and appropriations affecting early childhood programs.

B3. ASSESSMENT OF THE NEEDS OF THE MATERNAL AND CHILD HEALTH POPULATION GROUPS

DEMOGRAPHICS AND SOCIO-ECONOMIC CHARACTERISTICS OF NEW MEXICO

New Mexico was the 20th fastest growing state between 2000-2003. In 2003 New Mexico ranked sixth lowest in population density at 15.4 persons per square mile and fifth in size at 121,365 square miles. The total population was estimated at 1,874,614 persons, a 3.1% increase since 2000 and 0.64% of the total U.S. population. New Mexico remains a young state with 30% of the population under age 20, compared to 28.1% for the U.S; an estimated 12% was over age 65, compared to 12.3% for the U.S.

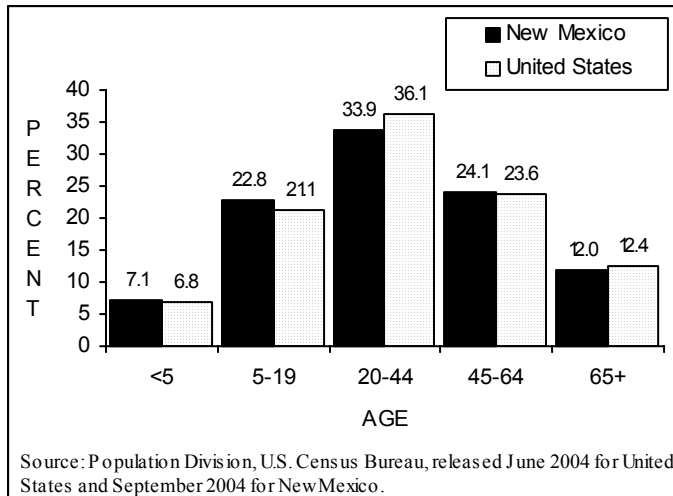
New Mexico Population Density, 2003:



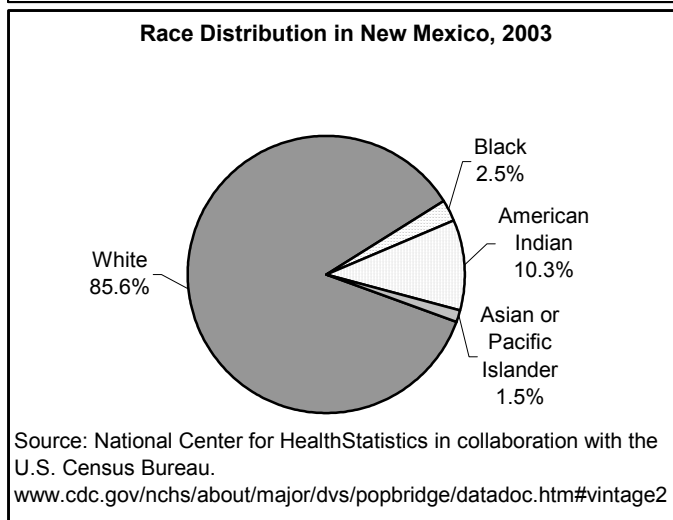
There are 33 counties in the state to which reference will be made throughout this document. The map shown here depicts population density: only 8 of the 33 counties had a density greater than 14.2 persons per square mile. The state has borders with Arizona to the west including a common

territory with the large Navajo Nation in the northwest corner; Colorado to the north; Texas to the east and the southern edge to the hook on Dona Ana county; and a common border with Mexico in the southwestern corner.

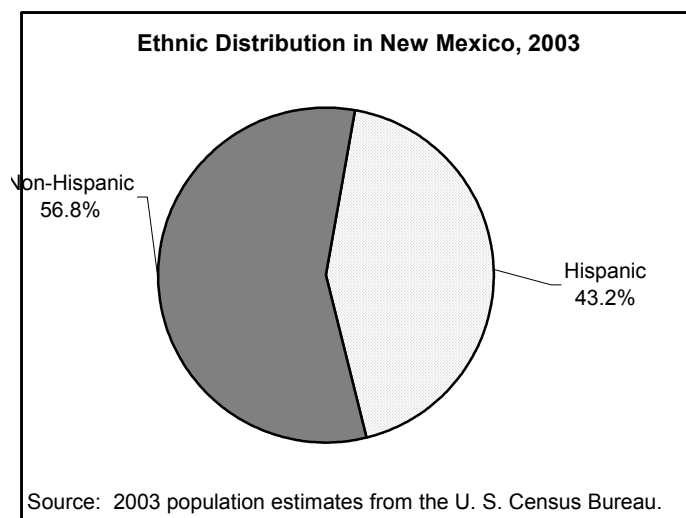
New Mexico became a “minority majority” state in 2000, with the combined Hispanic, Native American, Asian and African American population being greater than non-Hispanic Whites. There were significant differences in many health and social indicators between racial and ethnic groups; the NM Department of Health (DOH) has made significant strides in assuring that policies and programs be culturally competent. According to 2003 population estimates, 85.6% of New Mexicans were white (includes individuals of Hispanic origin), 2.5% were Black, 10.3%



were American Indian and 1.55 were Asian or Pacific Islander. Hispanics made up 43.2% of the population; non-Hispanics 56.8%. An estimated 67% of N.M. children and 55% of adults were of a minority group. Nearly 55% of the state's children were Hispanic, the highest proportion of any state.

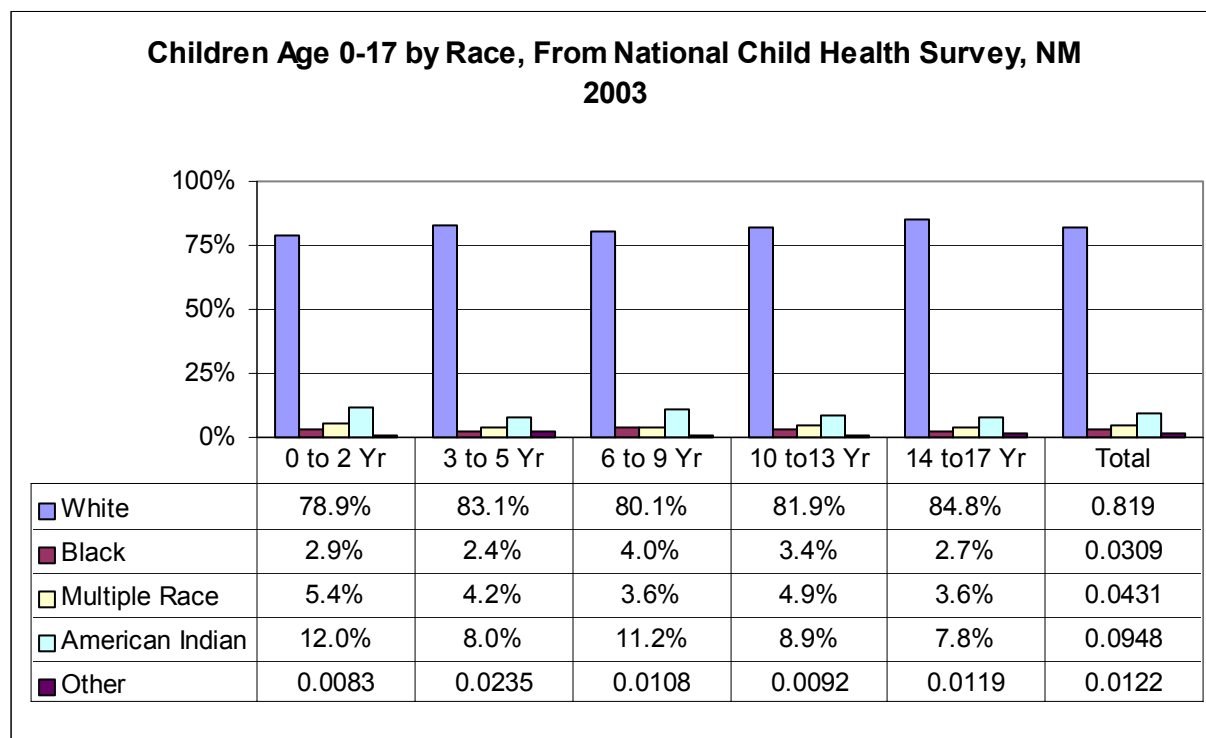


In 2003, NM had a population of 1,874,614 persons. It was the 20th fastest growing state between 2000-2003. It ranked 36th in total population in the US and had the sixth lowest population density in the country with an average 15.4 persons per square mile. NM remains a young state. In 2003 30% of the population was under age 20, compared with 28.1% for the US. Only 12% of the population was over age 65.

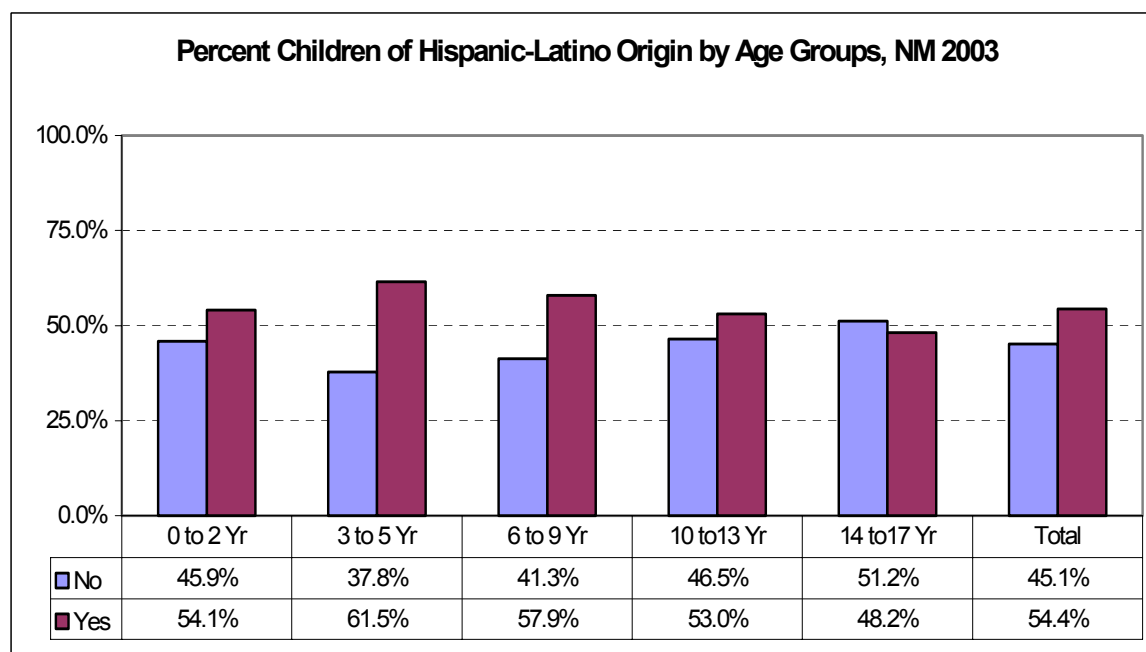


The racial and ethnic composition of the population is unique for the US: NM is one state in which the minority populations are indeed in the majority. Although 85.6% of the population was White, as seen in the next graph, 43.2% of the White population was Hispanic.

Among children, minority groups are in the majority. The first graph depicts the racial distribution; note that over 50% of White children are Hispanic White.

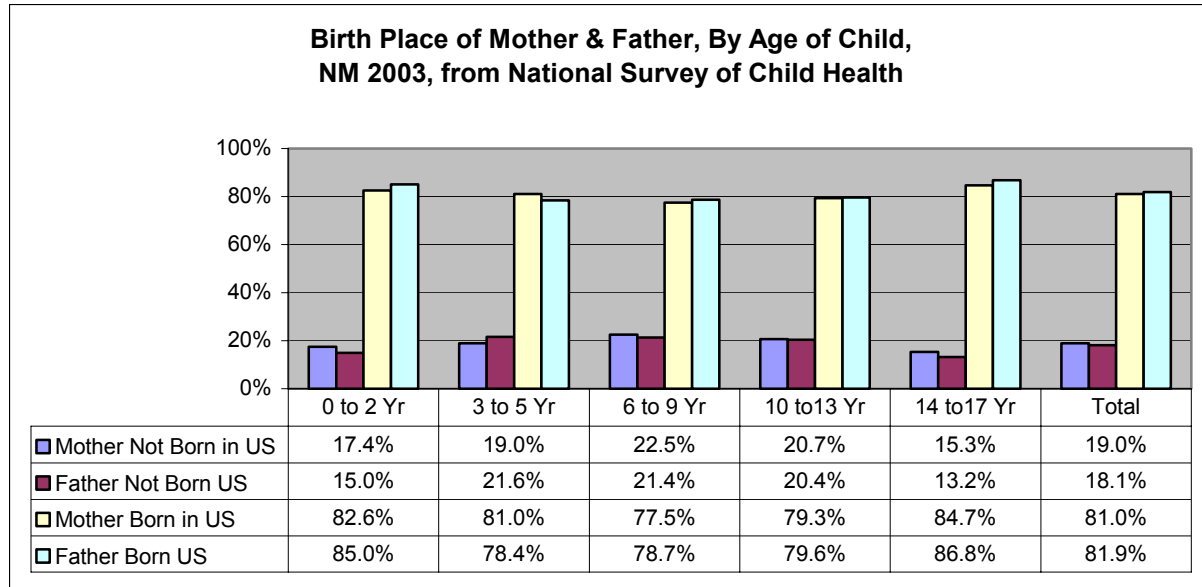


Data Source: Centers for Disease Control & Prevention, National Center for Health Statistics, State & Local Area Integrated Telephone Survey, National Survey of Children's Health, 2003. Analysis by NM MCH Epidemiology



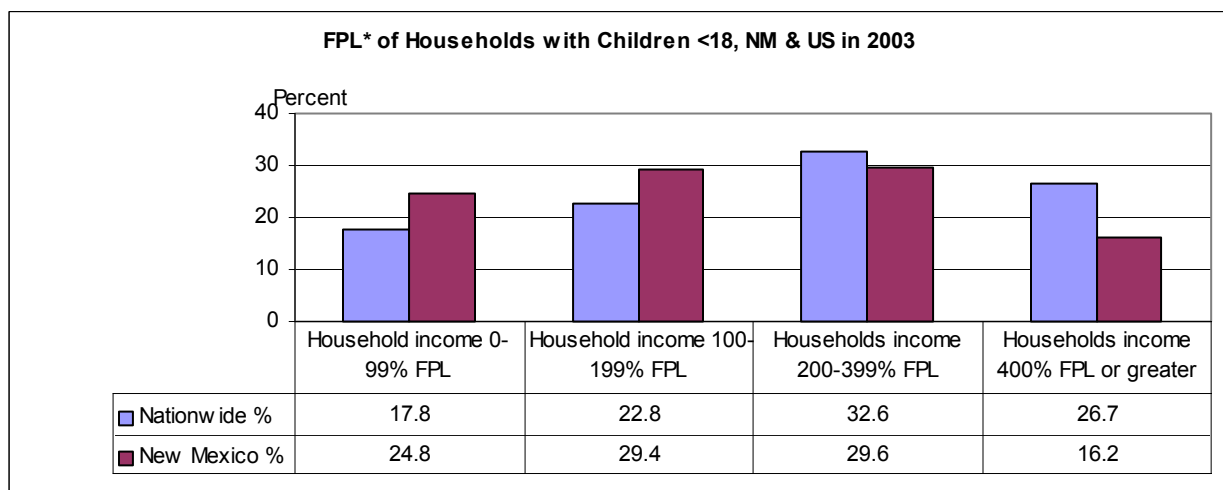
Data Source: Centers for Disease Control & Prevention, National Center for Health Statistics, State & Local Area Integrated Telephone Survey, National Survey of Children's Health, 2003. Analysis by NM MCH Epidemiology

An estimated 20% of NM children are born of immigrant parents; the majority of immigrants are of Hispanic origin. The reader is referred to the chapter on Immigrants and MCH for more information.



Data Source: Centers for Disease Control & Prevention, National Center for Health Statistics, State & Local Area Integrated Telephone Survey, National Survey of Children's Health, 2003. Analysis by NM MCH Epidemiology

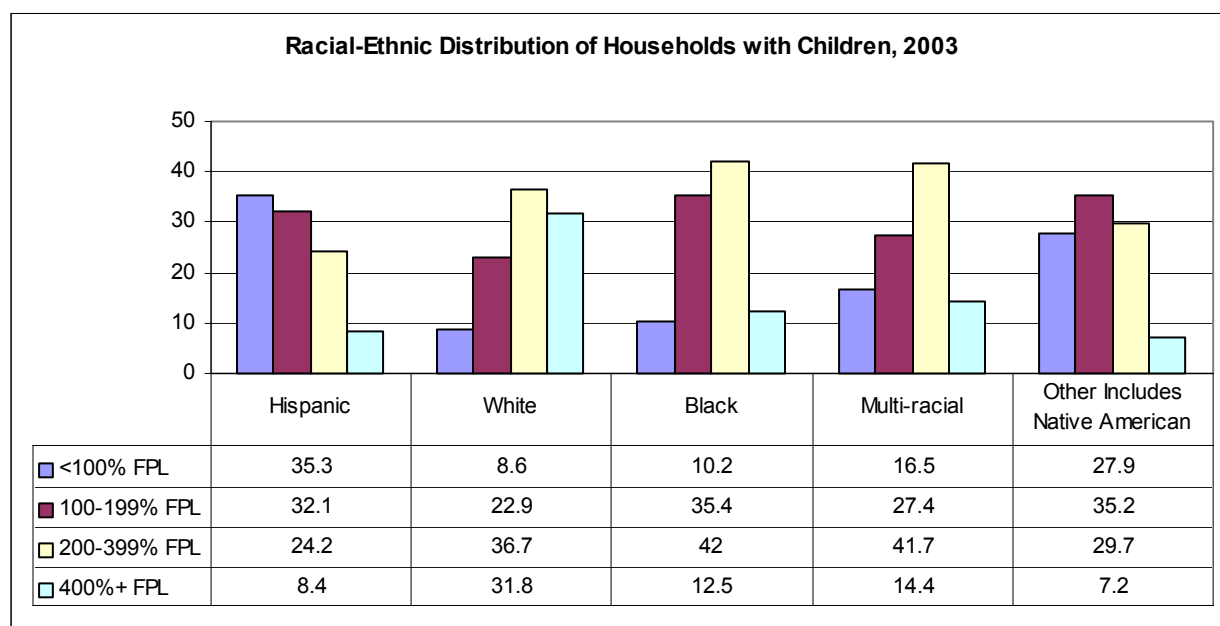
NM ranked 46th in per capita personal income at \$35,502, which was 81.1% of the national average. The state ranked 49th in 2003 for the percent of children in poverty: 24.5% of New Mexico's children compared to 17.8% in the U.S. The NM percent of near-poor families below 200% of poverty is 1.3 times that of the U.S. By contrast, the US has higher rates of higher income families than NM.



Source: Child and Adolescent Health Measurement Initiative (2005). National Survey of Source: Children's Health, Data Resource Center on Source: Child & Adolescent Health website. Retrieved June 2005 from www.nschedata.org.

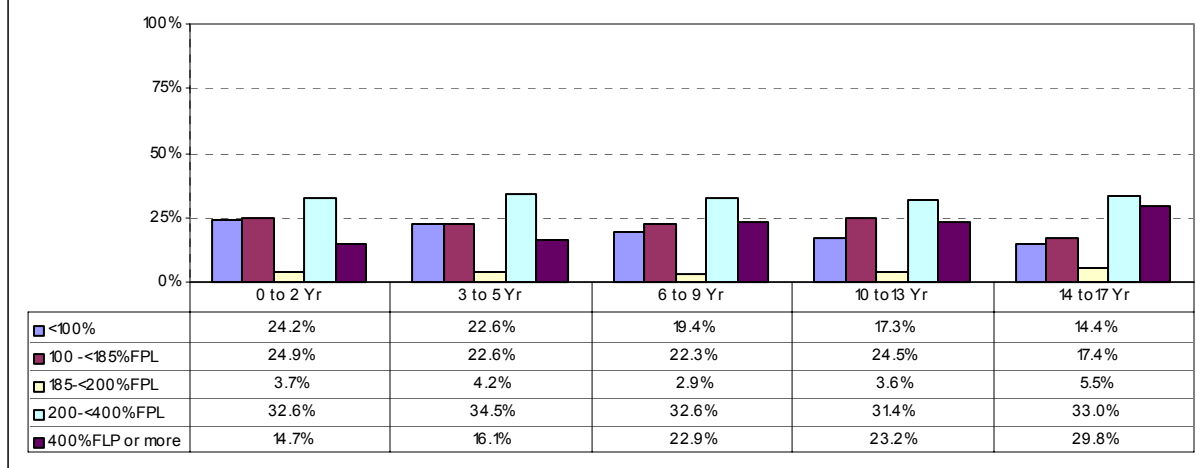
What is rarely shown in poverty statistics are the proportion of the population that lives in extreme poverty, below 50% of the FPL: an estimated 11% of NM children or about 55,619 were affected in 2002. 14% of NM children or 70,787 lived between 50-99% of the FPL.

The key issues that affect the health of the MCH population are the high rate of poverty in the state and the disproportionate burden of coping with less social advantage, particularly among minority groups who make up, indeed, the majority of this population. Gaps and disparities are seen consistently among teens, parents with only a high school education or less, and single parents. These characteristics translate into greater proportions of health risk behaviors, and lower access to and use of primary preventive care or specialty care. Although the state has made progress in reducing the proportion of the population that has no health insurance, critical gaps persist. There is a significant challenge in assuring access to care for the working poor and immigrant families who come into the state – many who pay taxes on their income.



Source: Child and Adolescent Health Measurement Initiative (2005). National Survey of Source: Children's Health, Data Resource Center on Source: Child & Adolescent Health website. Retrieved June 2005 from www.nschedata.org.

Percent Households with Children Age 0-17 by Age Child and Federal Poverty Levels, NM 2003



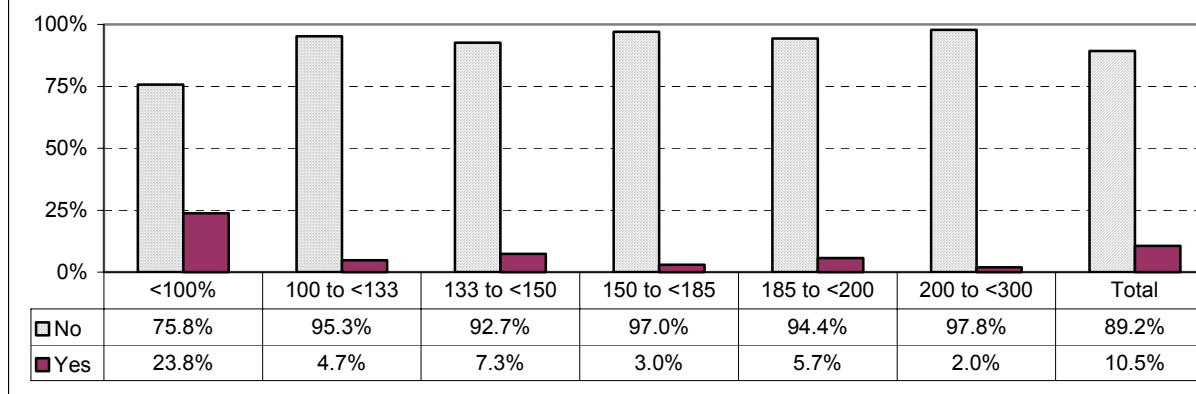
Data Source: Centers for Disease Control & Prevention, National Center for Health Statistics, State & Local Area Integrated Telephone Survey, National Survey of Children's Health, 2003. Analysis by NM MCH Epidemiology

As expected, a greater percent of households with infants and toddlers age 0-2 and 3-5 years of age live $\leq 100\%$ FPL. As children get older, the proportion of families in poverty decreases. This table also shows the proportion of children who are potentially eligible for Medicaid ($<185\%$ FPL) and for S-CHIP (185-200% FPL) although the actual eligibility for S-CHIP is 235% of FPL.

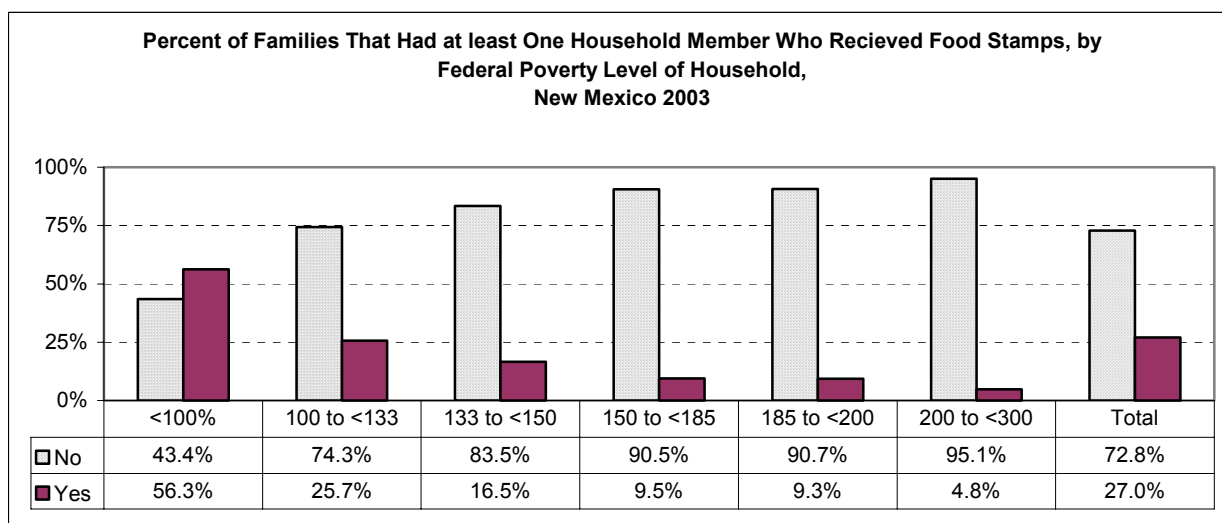
While over 24% of families with children lived $\leq 100\%$ FPL:

- ❖ less than $\frac{1}{4}$ of poverty level households had a member who actually used the TANF or cash assistance programs;
- ❖ just over $\frac{1}{2}$ of poverty level households had a member who actually used the food stamp program.

Percent of Families That Had at least One Household Member Who Received Cash Assistance such as TANF, by Federal Poverty Level of Household, New Mexico 2003



Data Source: Centers for Disease Control & Prevention, National Center for Health Statistics, State & Local Area Integrated Telephone Survey, National Survey of Children's Health, 2003. Analysis by NM MCH Epidemiology



Data Source: Centers for Disease Control & Prevention, National Center for Health Statistics, State & Local Area Integrated Telephone Survey, National Survey of Children's Health, 2003. Analysis by NM MCH Epidemiology

The prevalence of poverty and issues related to the health of this population will be found through out this needs assessment document.

Food insecurity in New Mexico was 1.32 times that of the nation in 2002 and the state was among the 5 worst states for that period. For food security with hunger, an estimated 3.8% of NM households were affected; the state ranked 12th worst.

Changes in prevalence rates of food insecurity and hunger, 1996-98 (average) to 2000-02 (average) United States and New Mexico						
	Food Insecure, With or Without Hunger			Food Insecure With Hunger		
	1996-1998	2000-2002	% Change	1996-1998	2000-2002	% Change
United States	11.3%	10.8%	-0.5*	3.7%	3.3%	-0.4*
New Mexico	16.5%	14.3%	-2.2	4.8%	3.8%	-1.0*

*Change was statistically significant with 90-percent confidence ($t > 1.645$).
 1 Statistics for 1996-98 revised to account for changes in survey screening procedures introduced in 1998. Source: Prepared by ERS using data from Current Population Survey Food Security Supplements.

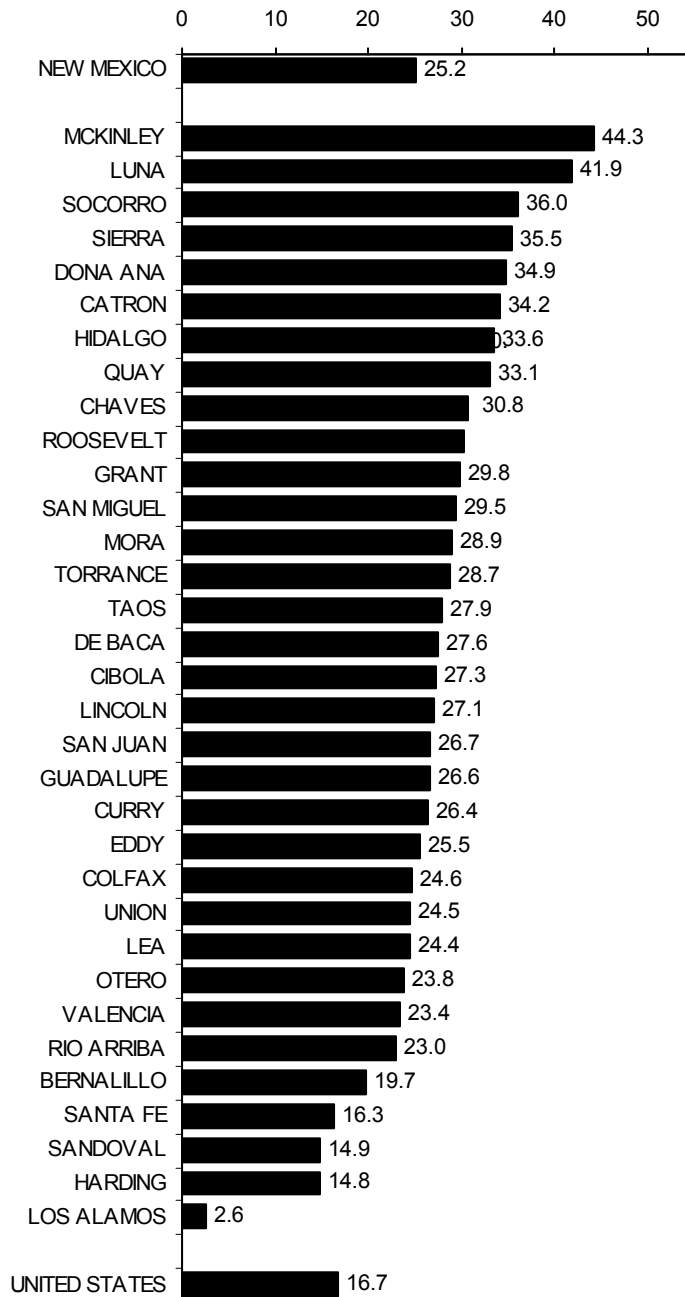
Among new mothers, issues of food security were explored, NM PRAMS 2002 found that 86% had enough food and of the 14% who did not have enough to eat, 3.5% were food insecure – as defined by having hunger and they often did not have enough food to eat.

EDUCATION: In 2003, NM ranked 46th of 50 states in high school graduation rates. In 2003, 80 percent of people 25 years and over had at least graduated from high school and 24 percent had a bachelor's degree or higher. Nearly 20% of the population had less than a 12th grade education; 27.39% were high school graduates. The three key dimensions of health: health outcomes, health behaviors and access to/use of health services are all related to educational levels in NM. This has been well documented for mothers of live born infants since 1997 from the NM Pregnancy Risk Assessment Monitoring System (PRAMS and for adults over 18 years of age in the NM Behavioral Risk Factor Surveillance System (BRFSS).

Among people 16 to 19 years old, 10 percent were dropouts; they were not enrolled in school and had not graduated from high school. The total school enrollment in New Mexico was 515,000 in 2003. Preprimary school enrollment was 55,000 and elementary or high school enrollment was 338,000 children. College enrollment was 122,000. American Community Survey, US Census, 2003 www.census.gov/acs.

Employment: Unemployment is a critical issue for New Mexico. In 2000, the NM unemployment rate was 4.8%; and in 2005 it was 6%. In 2003, an estimated 70% of NM households had at least one full-time worker v. 73% in the US; 9% were part-time in NM v. 7% in the US; and 21% were households with no employed persons in NM v. 19% in the US. The impact of unemployment on families and children is significant, not only for the stark experience of being unemployed but also for the emotional stress it places on parents. New mothers reported exceptionally high levels of family stressors associated with poverty in NM PRAMS in 2003: 6.69% had been homeless; 14.2% reported their husband or partner had lost his job; 12.5% of new mothers lost their job; and 25% lived with the stress of bills they could not pay.

**Children <18 and At or Below Federal
Poverty Level, Percent by County, Rank
Order, 2002**



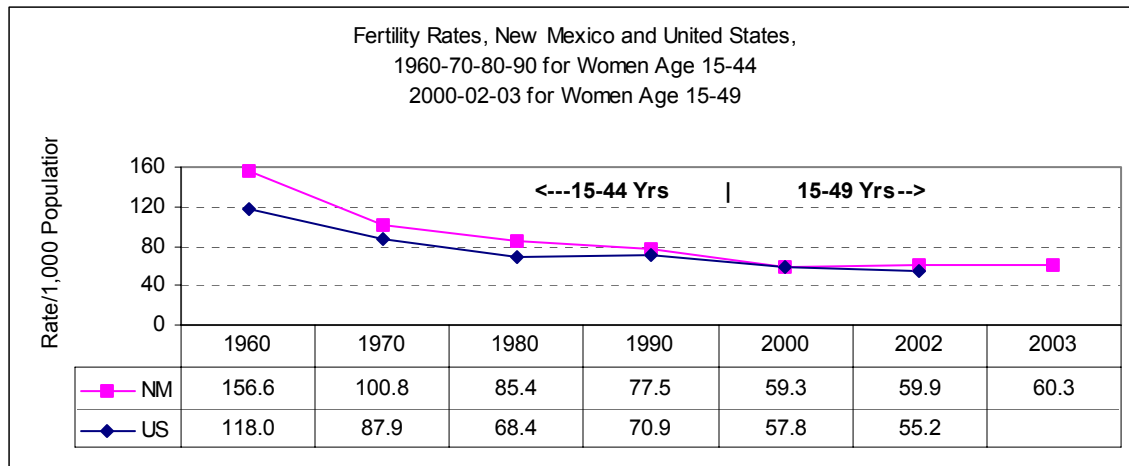
Source: U.S. Census Bureau, Small Area Income & Poverty Estimates, released December 2004.

2/3 of NM counties have over 25.2% of children <age 18 and who are living at or below the federal poverty level.

11 of 33 counties have a smaller percent of children living in poverty than the statewide estimate of 25.2% of children

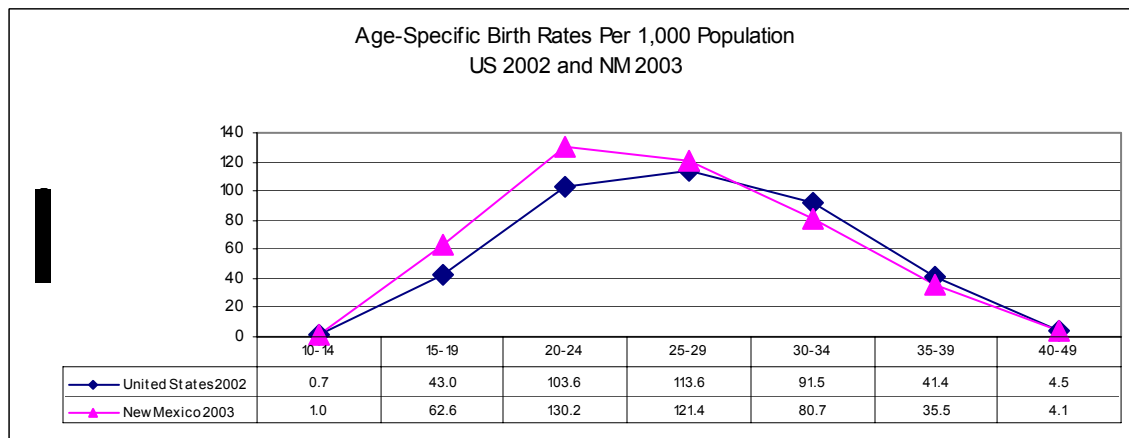
THE HEALTH OF NEW MEXICO PREGNANT WOMEN AND MOTHERS: THE NEW MEXICO BIRTH POPULATION

The fertility rate in NM has been higher than the national rate for decades, although since 2000, the state rate became closer to the national rate.



Source: New Mexico Vital Records and Health Statistic. Please note data from the two sets of rates in use since 2000: Age 15-44 through 2000 and Age 15-49 from 2000 and forward in time.

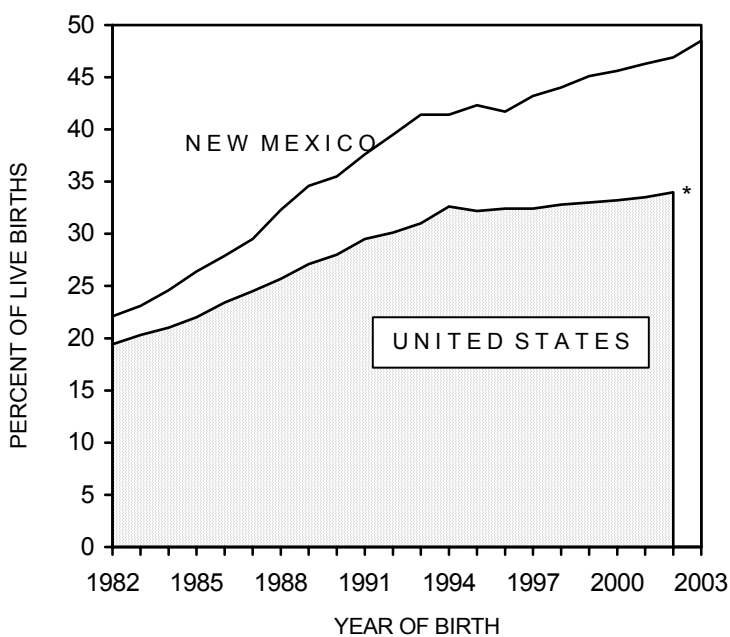
The age specific birth rates for 2003 are similar to the nation although there are higher rates among teens and young women up until births to women 25 years of age and older. The rate ratio for New Mexico to the United States was 1.45 times for teens age 15-19; 1.25 times for women age 20-24 years of age. The rate ratio for women age 20-24 was only 1.06; and for older age groups the rate ratio was 0.8-0.9, indicating that the US rate was greater.



Source: New Mexico Vital Records and Health Statistic.

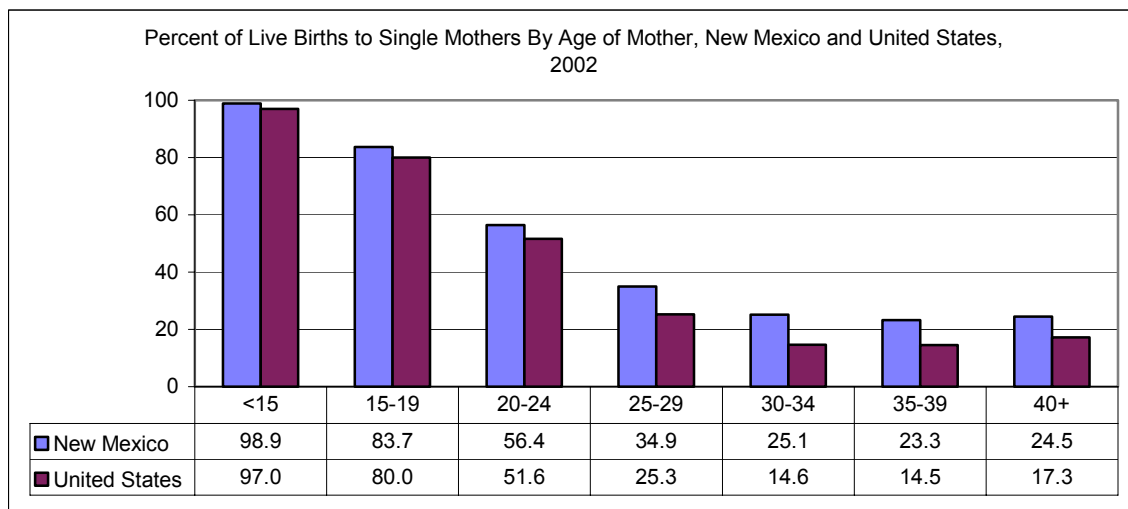
The proportion of births to single mothers has increased in NM and in the US for the years 1982-2003; and the NM percentage has exceeded the national percentage since 1965. Births to single mothers increased 48.5% in 2003, more than double the proportion of 22.1% in 1982.

Percent of Live Births to Single Mothers, NM and US, 1982-2003



The percent of single mothers by age of mother decreases as mothers are older, from 98.9% among very young mothers under age 15 years to 24.5% among mothers age 40 years or older.

U.S. Source: CDC, National Center for Health Statistics, NVSR .
 * 2003 US data not available at time of publication

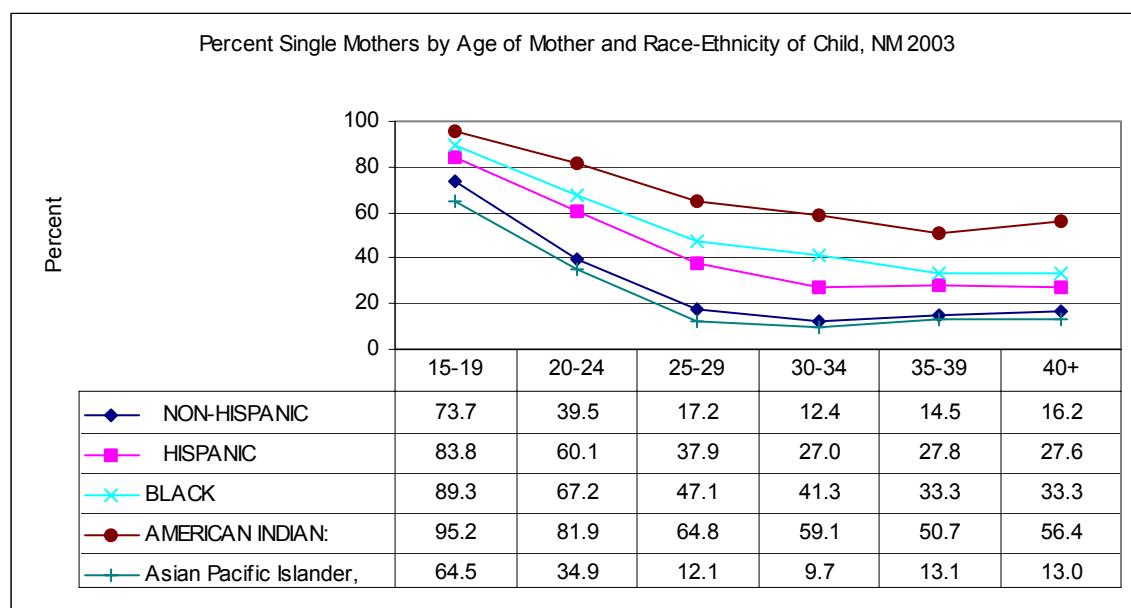


Across all age groups, a higher proportion of NM mothers were single than US mothers. Differences were insignificant for teens and young mothers age 20-24. Differences were greater for mothers age 25 and older.

	Age of Mother						
	<15	15-19	20-24	25-29	30-34	35-39	40+
New Mexico	98.9	83.7	56.4	34.9	25.1	23.3	24.5
United States	97.0	80.0	51.6	25.3	14.6	14.5	17.3
Rate Ratio NM:US	1.02	1.05	1.09	1.38	1.72	1.60	1.42

Source: New Mexico Vital Records and Health Statistic.

A high proportion of single mothers have greater support needs than those who are married. Compared to couples, they tend to have less income, lower educational attainment and a higher proportion of health risk behaviors as described in subsequent chapters. In order to work strategically to improve health status, the state's maternal and infant health care providers, in public and private sector, need to plan services so that they are culturally appropriate to the race-ethnicity and cultural affiliations of new mothers. The distribution of births to single mothers by race-ethnicity is shown below. A large body of research is available to the state on socio-cultural factors associated with single mother-hood among Hispanic, Black and American Indian populations.



Source: New Mexico Vital Records and Health Statistics

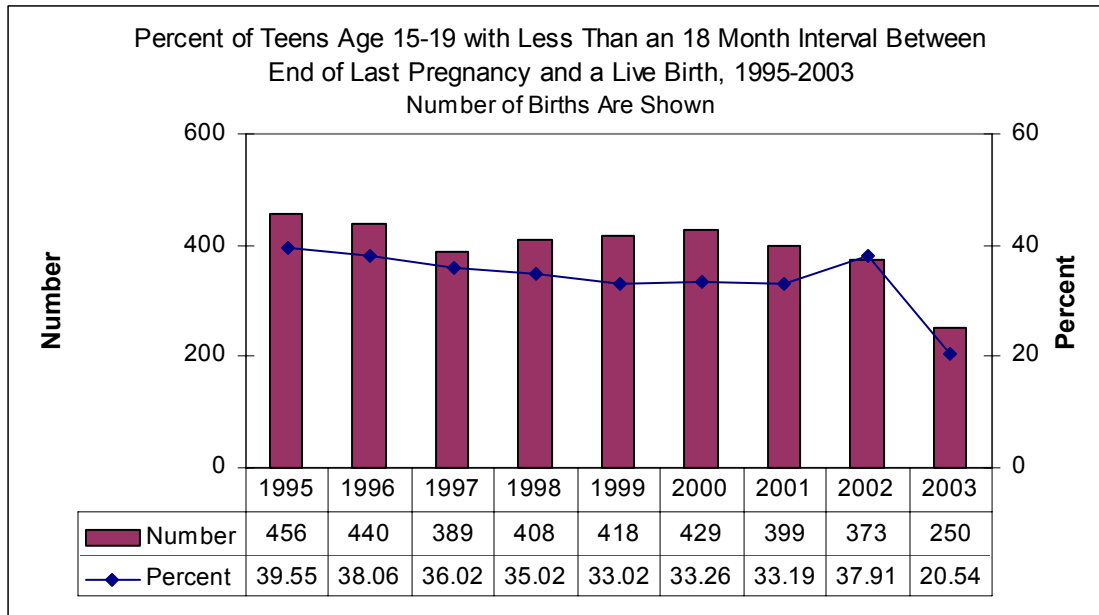
The 2003 NM births by age of mother and age of father depict the age differences that have prevailed in the state for many years: females begin at ages younger than males but the data must be regarded with great caution. Information about father's age is absent on over 20% of birth registrations. By NM law, birth certificates of infants born to single mothers, without statement of paternity, contain no information on the father.

**PERCENT OF LIVE BIRTHS By AGE OF MOTHER AND AGE OF FATHER
NEW MEXICO RESIDENTS IN 1990, 2000 AND 2003**

AGE OF PARENT	PERCENT OF LIVE BIRTHS					
	MOTHER			FATHER		
	2003	2000	1990	2003	2000	1990
<15	0.3	0.3	0.3	0.0	0.0	0.0
15-19	16.3	17.1	15.9	4.9	4.6	3.4
20-24	31.7	30.0	28.9	20.1	17.1	15.4
25-29	24.8	24.8	28.5	21.0	19.8	23.1
30-34	17.0	16.9	17.9	17.2	16.0	18.2
35-39	7.9	8.7	7.1	9.4	10.0	9.0
40-44	2.0	2.0	1.2	4.4	4.0	3.5
45-49	0.1	0.1	0.1	1.5	1.4	1.0
50 +	0.0	0.0	0.0	0.7	0.6	0.5
Unknown	0.0	0.1	0.1	20.8	26.3	25.9

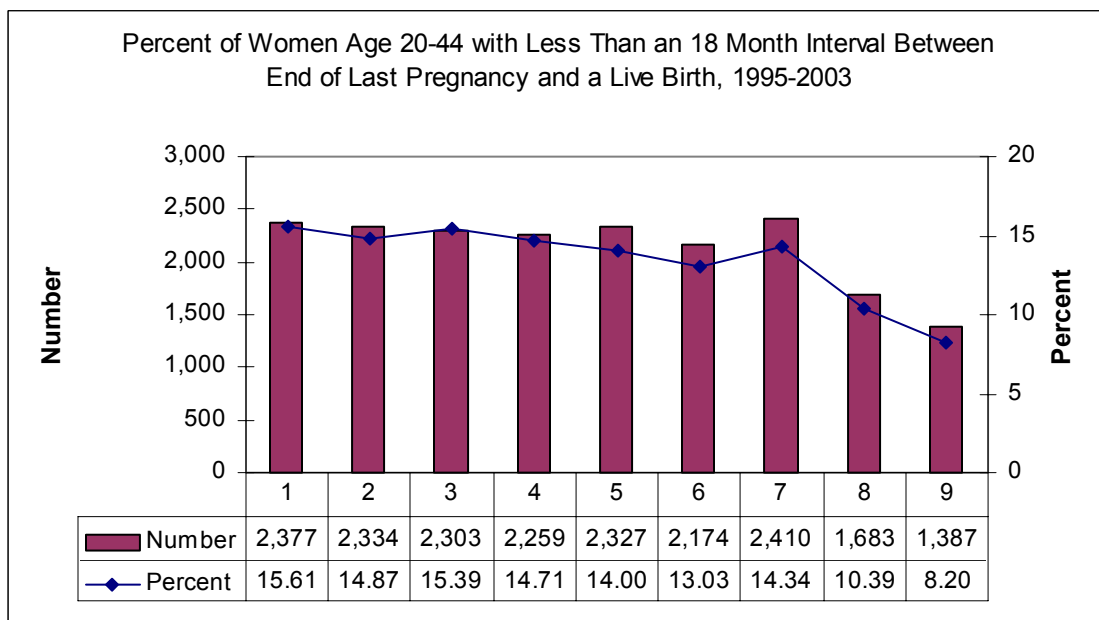
Note: Due to rounding, percents may not add up

Birth Spacing of at least 24 months is recommended to promote the health of both mother and infant. For teens, the majority of whom are single and have many needs for support, adequate spacing can be a critical issue for health and wellbeing. This indicator appears to have a dramatic decrease in 2003; number and percent lower than past years. These data will be tracked closely in coming years and additional analysis is needed.



Source: New Mexico Vital Records and Health Statistics

The proportion of births with <18 month interval from last pregnancy among women 20-44 years of age was half that of young teens, with an annual average decrease of 7% between 1995-2003. The proportion in 2003 was almost half that of 1995. Again, use of NM PRAMS data may provide insight into the decline.



Source: New Mexico Vital Records and Health Statistics

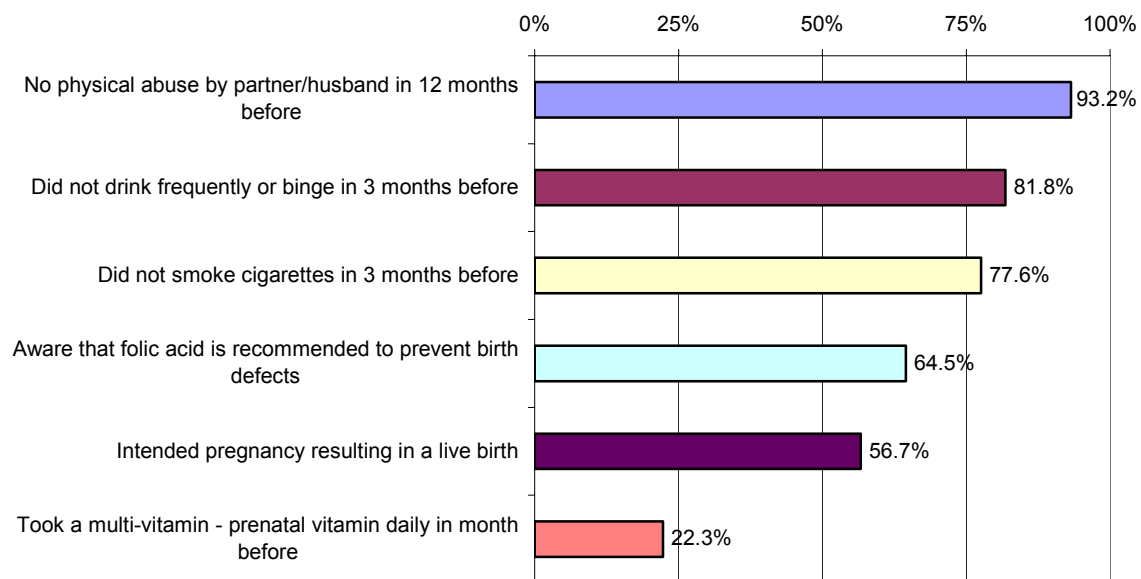
NM PRAMS found that proportion of women using post-partum contraception increased from 78.7% in 1998 to 88.6% in 2002, with very little variation by age group of mother. PRAMS data does not capture the duration of use.

Pregnancy Terminations: Reporting of legal induced abortions became law in NM in 1977, and 1978 was the first full year of reporting. The numbers have varied between 4,500 and 5,500 since 1978. In the past five years 1997-2002 (2003 data not yet processed) the number has ranged from a high of 5,250 to a low of 4,865 (rates of 193.0 and 175.6 respectively). The NM abortion ratio in 2002, 175.6 per 1,000 live births, was 3.5% lower than the national figure. The ratio for non-Hispanic white females has been higher than that of other groups. There is no clear pattern of trend for NM in the past five years.

PRECONCEPTIONAL AND PRENATAL HEALTH OF NM MOTHERS

Optimal health –for prospective mothers and fathers - before a first pregnancy and between pregnancies is an important dimension of needs assessment regarding the health of pregnant women and mothers. NM PRAMS data was used to develop an index of preconceptional health in which only 12.6% ($\pm 1.3\%$) of prospective new mothers were prepared for a pregnancy using all of the criteria seen in the graph below:

Elements of a Healthy Preconception Index, NM 2001 - 2002



Data Source: NM PRAMS

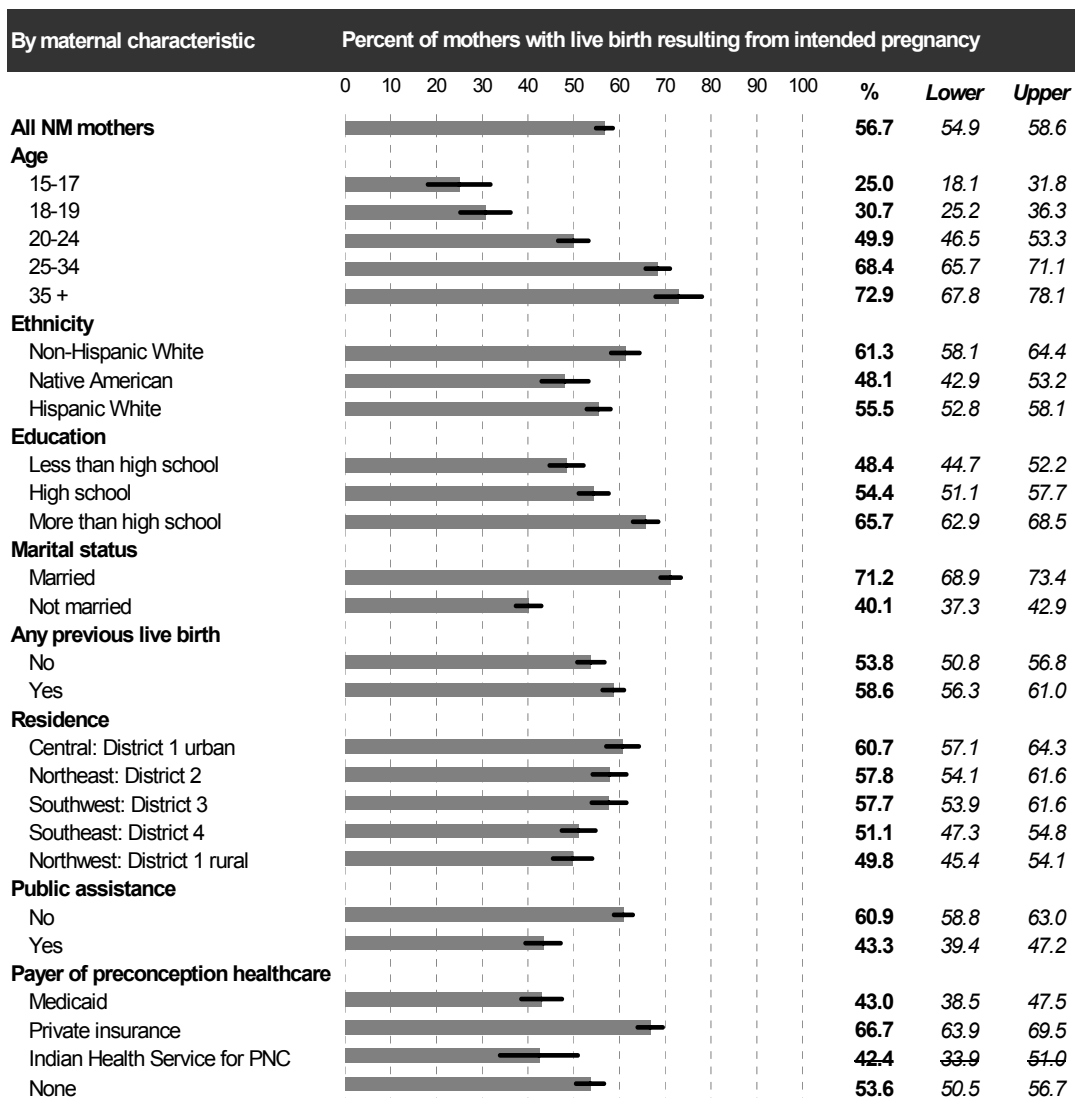
State Performance Measure 3: to reduce the proportion of live births resulting from an unintended pregnancy to less than 30%.; and conversely, to increase the proportion of intended pregnancy.

The Healthy People 2010 goal is to increase the number of pregnancies that are intended from 51% in 1998 to 70%. This goal is based on pregnancies, not live births. Planned births (intended pregnancies) are associated with healthier maternal behaviors and healthier infant outcomes than those that are not. An intended pregnancy may, if the

concept is important, lead families to take time for preconception planning. Unintended pregnancy is associated with adverse outcomes such as premature delivery, low birth weight and small size for gestational age. These may result from maternal behaviors

Intended pregnancy resulting in live birth

NM PRAMS, years 2001-2002. "Lower" and "Upper" refer to the error margin of the 95% confidence interval; a strikethrough indicates a large margin and the need to use the data with caution. Number of respondents=3161, population=52072. Sample and weighted numbers, methods and variable definitions are in Appendix. Map of NM districts precedes this section.



associated with not having the intention of getting pregnant.

In all PRAMS states, the rate of intended pregnancy among women with live birth ranged from 46.6% to 68.4% in 2000. In New Mexico, 2001-2002:

- ❖ 57% of NM mothers intended their pregnancy
- ❖ 44% did not, for whom
 - 33% of live births resulted from mistimed and 11% from unwanted pregnancy.
 - There were at least 8,100 mistimed and 2,300 unwanted pregnancies resulting in live birth in 2002.
 - From 1998 to 2002, rates of intended, mistimed and unwanted pregnancy were stable.

Intended pregnancy increased with maternal age, ranging from 25% of 15 to 17-year-olds to 72.9% of women 35 years or older. Educational level and marital status were also associated with intention. Intended pregnancy was less likely among recipients of public assistance (43%) than non-recipients (61%) or among women with Medicaid (43%) or no payer of prenatal care (54%) than women with private insurance (67%). Native Americans (48%) were less likely to intend than non-Hispanic whites (61%), and Hispanics were in between (56%). NM PRAMS estimated that in 2002, 1,816 (± 342) Medicaid women with live birth did not want their pregnancy. For these births, Medicaid paid an estimated \$15.2 million dollars ($\pm \2.9 million) for pre-natal care, delivery, and the first year of the infant's care.

Pre-pregnancy Use of Contraception: For sexually active couples not desiring a pregnancy, motivation to use contraception and education about correct use are essential. Payers of care stand to gain by providing effective contraception. The financial costs of

an unintended pregnancy were estimated at \$3,795 in a managed care setting and \$1,680 in a publicly funded program from a study in 1995, and *any* method of contraception was very cost-effective when compared to no method.¹ Among women who were not trying to get pregnant, 43% were and 57% were not using contraception at conception. Native Americans (70%) were more likely to be non-users (v. 53% of non-Hispanic whites or 54% of Hispanics). Non-use was more likely among women without a previous live birth (62%) than those with one or more. Within other subgroups there were no striking disparities.

Among women who were not trying to get pregnant, the most common reason for not using a method at conception was that the respondent did not mind getting pregnant (41%), followed by problems getting birth control (29%) and their partner's wish not to use a method (22%).

Use of contraception is not entirely determined by intention: in all PRAMS states, among women with unintended pregnancy, 37.7% to 56.0% were using contraception at conception. If regular contraception is not used or if it fails, emergency contraceptive pills (ECPs) are an effective and safe way to reduce unwanted pregnancies. ECPs can reduce the risk of pregnancy by 89% and do not cause abortions. Advance provision of emergency contraceptive pills (ECPs) can save \$263 to \$498 in a managed care setting and \$99 to \$205 in a public payer setting. NM is the fourth state to allow pharmacists to prescribe ECP. In addition, hospitals are required by law to inform rape survivors about ECP and offer treatment. The NM ECP workgroup promotes pharmacy access and education about ECP; and persuaded the NM DOH and the NM Medical Society to endorse prevention of unintended pregnancy as a Clinical Prevention Initiative. Intended

pregnancy (wanting the pregnancy at the time of conception or sooner) was linked with healthier preconception behaviors and experiences than mistimed (wanted later) or unwanted pregnancy.

- ❖ Daily use of a multivitamin was more likely among women with intended (28.8%) than mistimed (14.0%) or unwanted (12.8%) pregnancies.
- ❖ Smoking cigarettes was less likely among intended than mistimed or unwanted pregnancies (16.8% v. 28.5% or 33.9%),
- ❖ Frequent or binge drinking (13.8% v. 22.0% or 29.5%) was less likely among intended than mistimed or unwanted.
- ❖ Physical abuse by a partner was less likely among intended (5.6%) than unwanted (11.5%) pregnancies.

Folic Acid Awareness and Use

If taken before conception and during early pregnancy, folic acid (a B vitamin) can help reduce the occurrence of neural tube defects (NTDs, birth defects of the spinal cord and brain) by at least 50-70%. The average lifetime cost per case of spina bifida is estimated at \$635,763 (\$279,210 direct costs). Health experts recommend that all women of childbearing age take 400 micrograms (0.4 mg) of folic acid daily. Women who have had an NTD-affected pregnancy should take 4 milligrams (4000 micrograms) daily. The Healthy People 2010 target is to increase pregnancies begun with optimum folic acid levels from 21% to 80%.

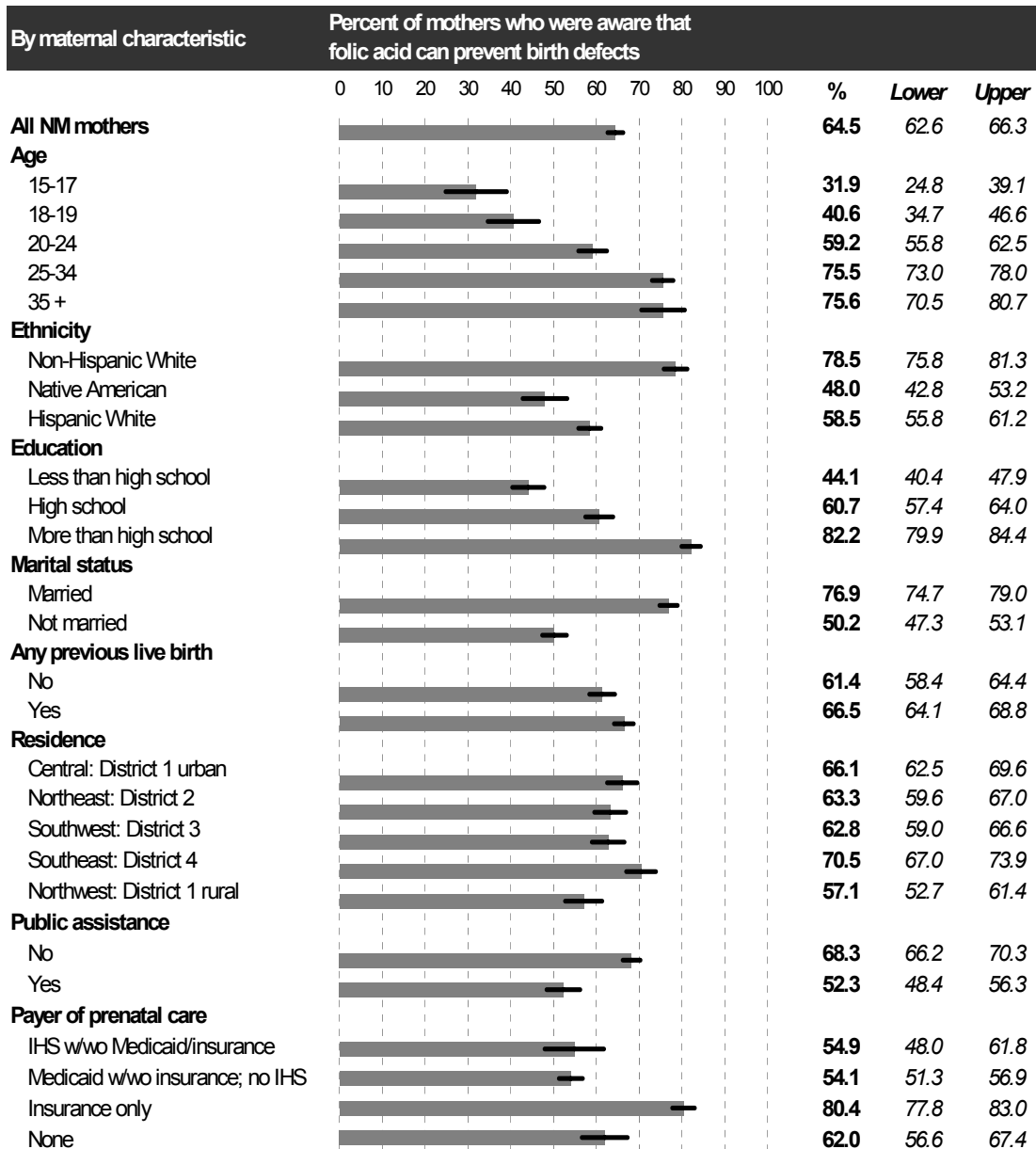
NM PRAMS found that twenty-two percent of new mothers in 2002 took a multi- or prenatal vitamin daily during the month before pregnancy. This means that among more

than 26,000 new mothers, only 5,876 took a multi/prenatal vitamin daily.³ Sixty-one percent did not take a multi/prenatal vitamin at all.⁴ Awareness that folic acid can help prevent birth defects has not increased (63.5% of mothers in 2002, Table 2 / Figure 2). Daily use of a multivitamin was more likely among women with more than high school education (33% v. 17% with high school, v. 14% with less than high school education); were married (29% v. 14% if not married); not on public assistance (25% v. 14% if on public assistance); or who had private insurance . The same characteristics were associated with awareness of folic acid benefits.

The NM Birth Defects Prevention Task Force, the WIC Nutrition Program, the Cooperative Extension Service and the Navajo Nation work to educate the public. Medicaid pays for prenatal vitamins with folic acid for mothers receiving prenatal but not family planning services.

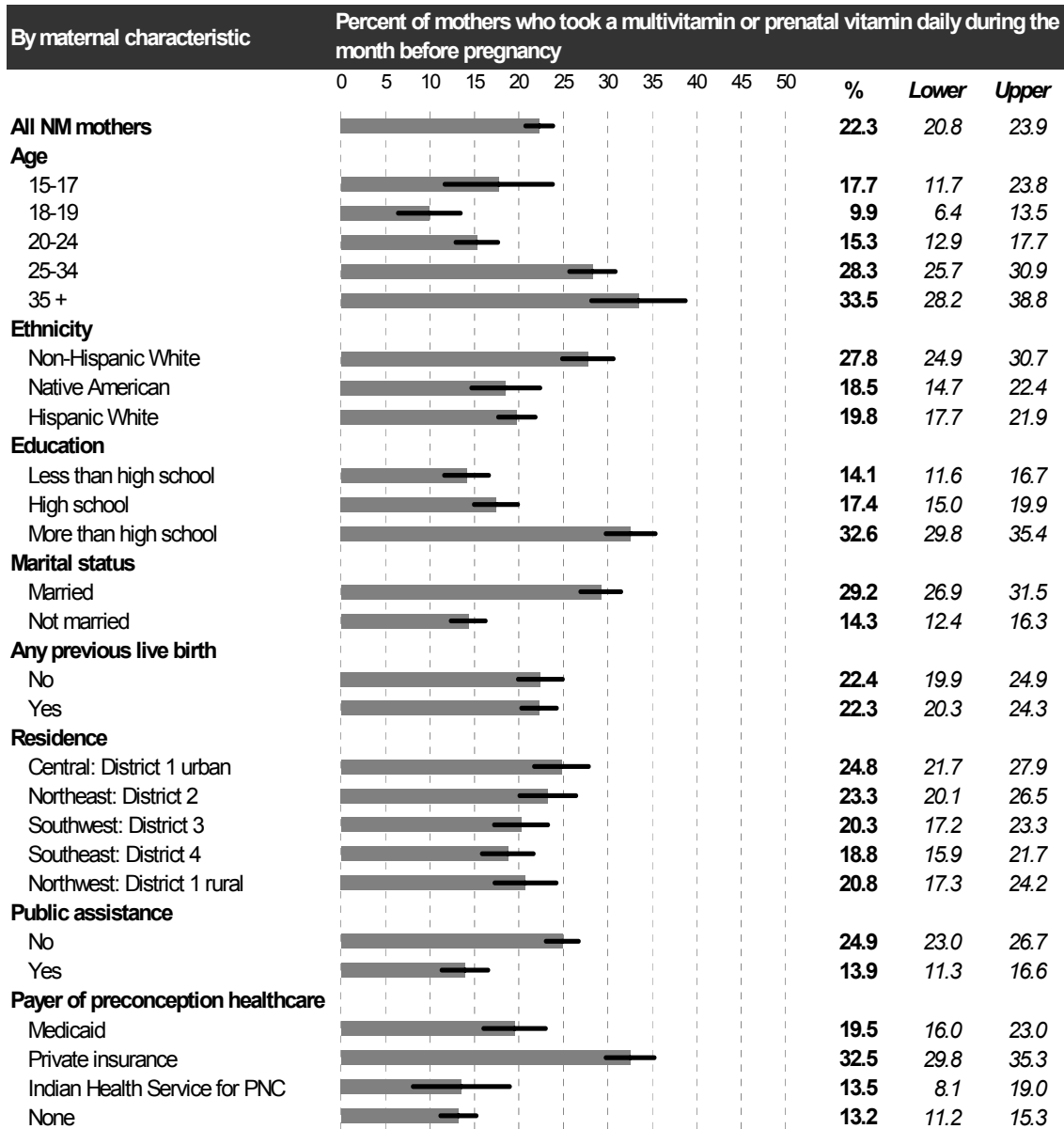
Awareness that folic acid is recommended to prevent birth defects

NM PRAMS, years 2001-2002. "Lower" and "Upper" refer to the error margin of the 95% confidence interval; a strikethrough indicates a large margin and the need to use the data with caution. Number of respondents=3161, population=52072.



Multivitamin use

NM PRAMS, years 2001-2002. "Lower" and "Upper" refer to the error margin of the 95% confidence interval; a strikethrough indicates a large margin and the need to use the data with caution. Number of respondents=3161, population=52072.



Maternal Alcohol Use:

Frequent prenatal exposure to alcohol is among the most commonly identifiable causes of mental retardation and neurodevelopmental disorders. Prenatal alcohol exposure is also associated with miscarriages, birth defects and growth disorders. The terms, Fetal Alcohol Syndrome (FAS), Alcohol-Related Neurodevelopmental Disorder (ARND) and Alcohol-Related Birth Defects (ARBD) identify infants affected by prenatal exposure to alcohol. For FAS, the first 3 to 8 weeks of pregnancy are the critical exposure period.

There is no known safe level of or time for prenatal alcohol. Thus, in 2005, the U.S. Surgeon General warned women who are pregnant or may become pregnant to abstain from alcohol consumption. The Healthy People 2010 objective is to increase abstinence from alcohol by pregnant women to at least 94%.

The prevalence of FAS in New Mexico for 1992 was estimated at 1 per 1000, comparable to other national estimates. In 1991, the estimated annual financial burden FAS placed on the nation was at least \$75 million.

In NM 2002, during the 3 months before pregnancy, 17% of women drank frequently or binged, and 46% drank some alcohol. In the last 3 months of pregnancy, 4% drank some alcohol. Frequent or binge drinking before pregnancy was more likely among those who were not married (24% v. 14%) or who were on public assistance (22% v. 17%).

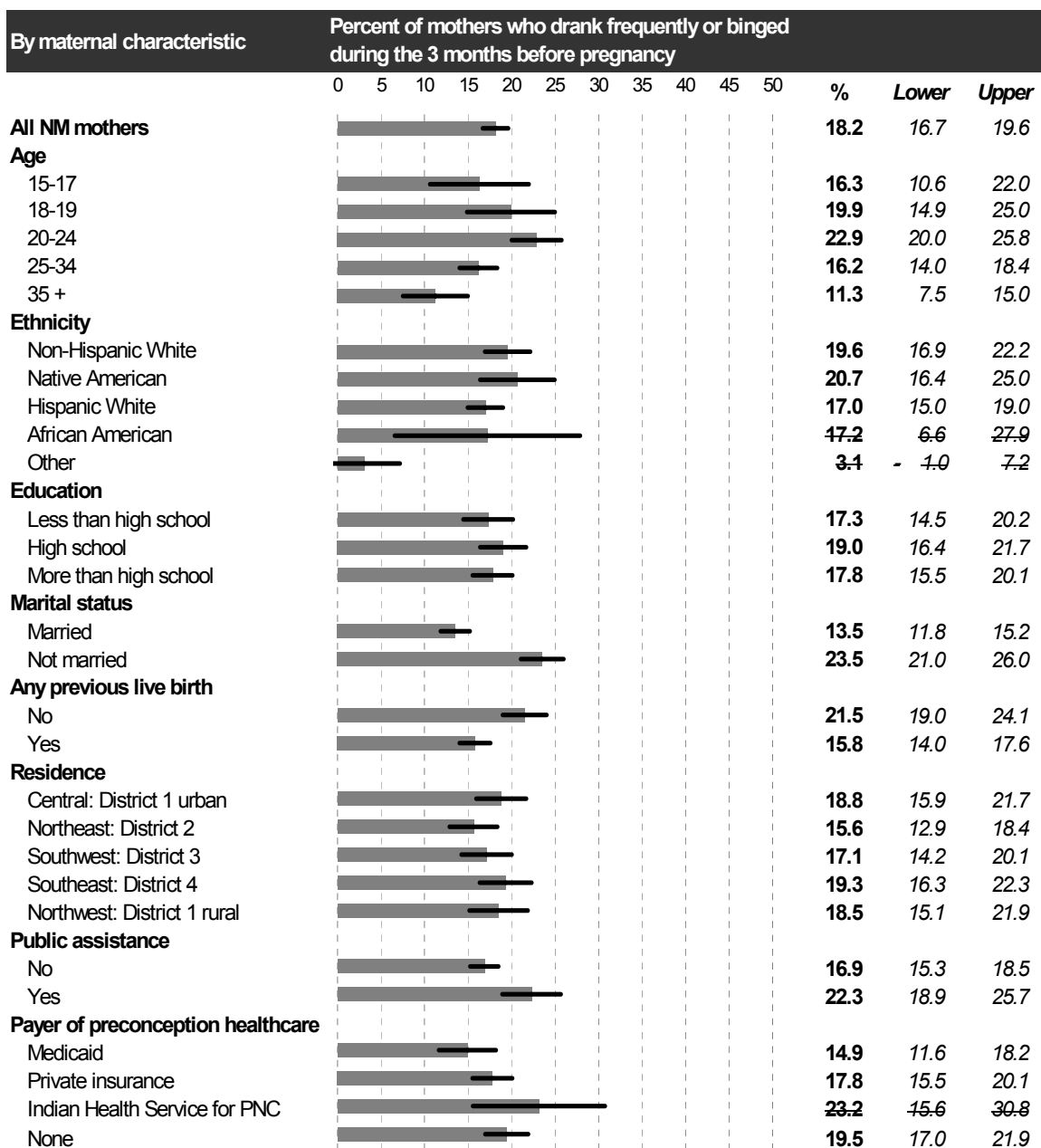
In 1996, the State Legislature passed HB 171 authorizing funds for a statewide Fetal Alcohol Syndrome Prevention Program. Community activities include media campaigns, developing and distributing informational materials and coordinating educational programs for pregnant women, professionals, families and students. When cases of FAS are identified, mothers are linked with services to prevent future FAS-affected infants.

The “Pregnant Pause Campaign”, launched in 1996, emphasizes that pregnant women should stop drinking. In New Mexico, women who have had a child with FAS usually gave birth to their first child in their teens, so prevention efforts target youth. A dynamic trainer facilitates a FAS curriculum developed for middle schools.

Frequent or binge drinking during the 3 months before pregnancy,

Defined as 7 or more drinks per week, or more than 4 drinks at a sitting. NM PRAMS, years 2001-2002.

"Lower" and "Upper" refer to the error margin of the 95% confidence interval; a strikethrough indicates a large margin and the need to use the data with caution. Number of respondents=3161, population =52072.



Cigarette smoking is the largest modifiable risk factor for pregnancy-related morbidity and mortality in developed countries. Smoking during pregnancy increases the risk of neonatal mortality, still-birth, preterm delivery, decreased birth weight and sudden infant death syndrome (SIDS); it is a major risk factor for gum disease, which is associated with preterm low birth weight. After pregnancy, maternal smoking increases the infant's risk of respiratory illnesses and SIDS. Smoking-attributable neonatal expenditures were estimated at \$366 million in 1996 or \$704 per maternal smoker.^{7,8} This would exceed \$1.6 million per year for New Mexico (1996 dollars multiplied by number of year 2002 births), of which Medicaid would pay at least \$800,000 – a conservative estimate, because Medicaid funds nearly half of all deliveries⁹ and serves women who are more likely to smoke during late pregnancy (15% v. 6% of non-Medicaid mothers).

Healthy People 2010 has set objectives to lower the prevalence of smoking among pregnant women to 1%, increase smoking cessation during pregnancy to 30% and reduce the proportion of children who are regularly exposed to tobacco smoke at home to 10%. Many women would like to quit smoking, however, barriers are not limited to knowledge and attitudes. Increased duration and level of smoking, more advanced age and smoking by the partner hinder cessation. Women who succeed in quitting tend to be better educated and have social support; they are less likely to be single parents. Encounters during prenatal care present a window of opportunity for smoking cessation. Clinical practice guidelines support evidence-based educational methods; these include brief sessions or self-help materials provided during routine prenatal visits. Smoking cessation interventions are cost-effective. A report from 1993 estimated that \$6.72 to \$17.18 spent on adverse out-comes were saved for each dollar invested in cessation.

Although New Mexico's rate of 8.5% in 2002 compares favorably with the nation's (11.4%), more than 2,000 newborns were exposed to maternal smoking during pregnancy. From 1998 to 2002, smoking rates decreased: before pregnancy, from 26% to 20%; during pregnancy, from 13% to 9%; and at the time of the survey, from 20% to 14%. However, there was no significant decrease for moderate to heavy smoking (15 or more cigarettes/day) during late pregnancy, which ranged from 2% in 1999 to 1% in 2002. Although approximately one-half of women who smoked before pregnancy said they quit during pregnancy (year 2001-2002), relapses were common. Thirty-two percent of women quit during pregnancy without relapsing, but 24% quit and relapsed. From 1998 to 2002, rates did not change significantly for smoking cessation among pre-pregnancy smokers, or for abstaining from cigarettes after delivery among those who smoked during pregnancy. For birth years 2001-2002 combined, 74% of all mothers recalled prenatal discussion of how maternal smoking could affect the baby. Of women who smoked during the 3 months before pregnancy, 85% ($\pm 1.9\%$) recalled such discussions; among these smokers, 82% ($\pm 2.8\%$) of successful and 89% ($\pm 2.6\%$) of unsuccessful quitters reported such discussions.

Smoking in the 3 months before pregnancy was higher among women

- with fewer than 12 years of education (27% v. 25% with high school or more than high school level);
- those receiving income from public assistance (36% v. 18% without assistance);
- non-Hispanic whites (28% v. 17% of Native Americans and 21% of Hispanics);
- and
- unmarried women (31% v. 15% of married respondents).

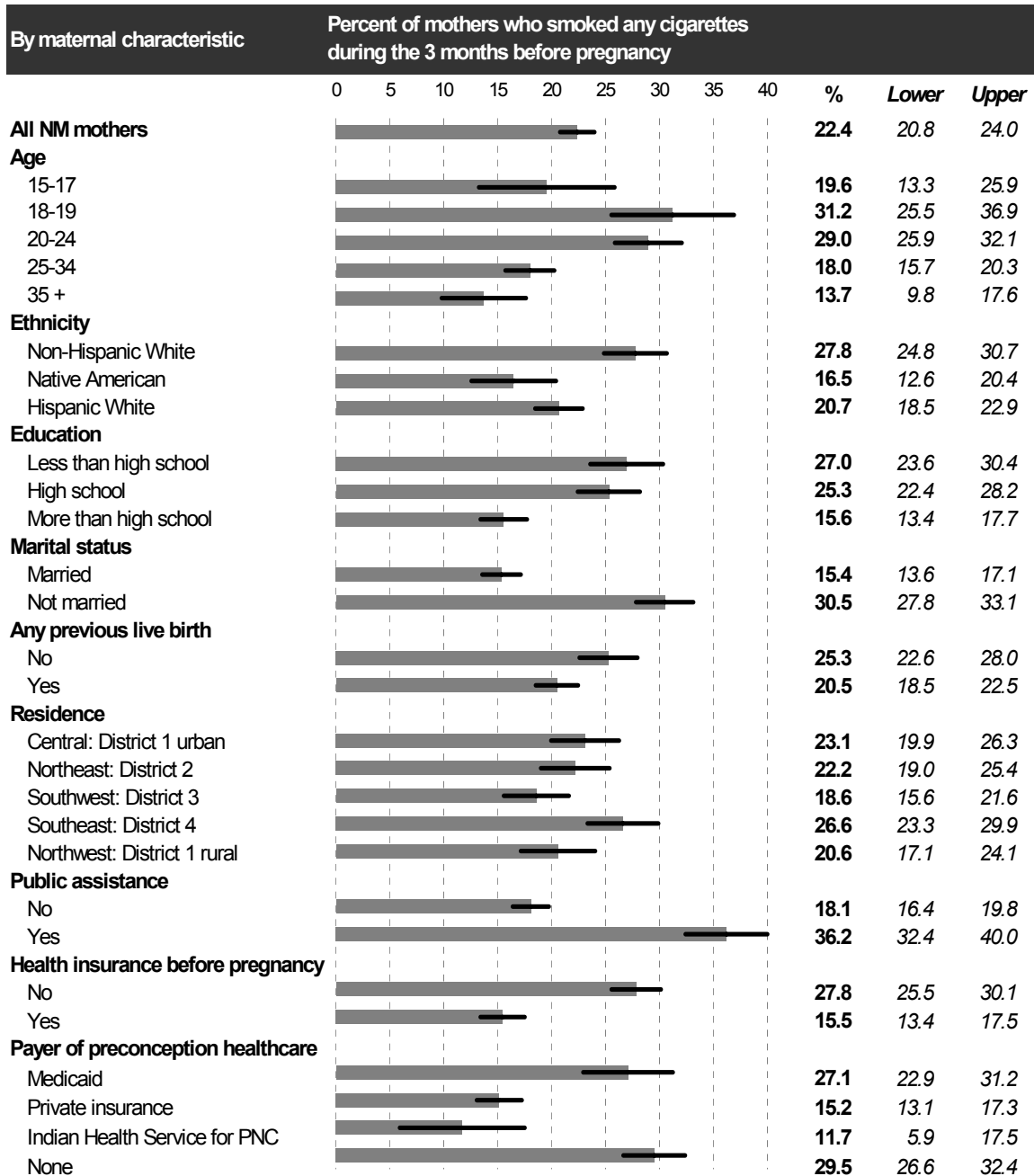
Medicaid carried an extra burden of smokers: 27% of women with preconception

Medicaid smoked before pregnancy v. 15% of those with private insurance or 12% of

those with Indian Health Service. Women 20 to 24-years old were more likely to smoke than young teens (15-17 years old) or women 25 years and older (Table 27). During pregnancy and in the post-partum period up to about 9 weeks similar patterns were observed.

Cigarette smoking during the three months before pregnancy

NM PRAMS, years 2001-2002. "Lower" and "Upper" refer to the error margin of the 95% confidence interval; a strikethrough indicates a large margin and the need to use the data with caution. Number of respondents=3161, population=52072.



State Performance Measure 6: Physical Abuse by Husband or Partner

Prenatal physical abuse of mothers can result in fetal death, early labor, preterm, low birth weight of the infant or maternal medical problems.¹ Children who are exposed to domestic violence are at increased risk for behavioral difficulties, emotional problems, poor academic performance, delinquency² and impaired health during adulthood. The Economic effects of abuse include increased medical costs in emergency rooms, where battered women may account for 22% to 35% of women seeking care.

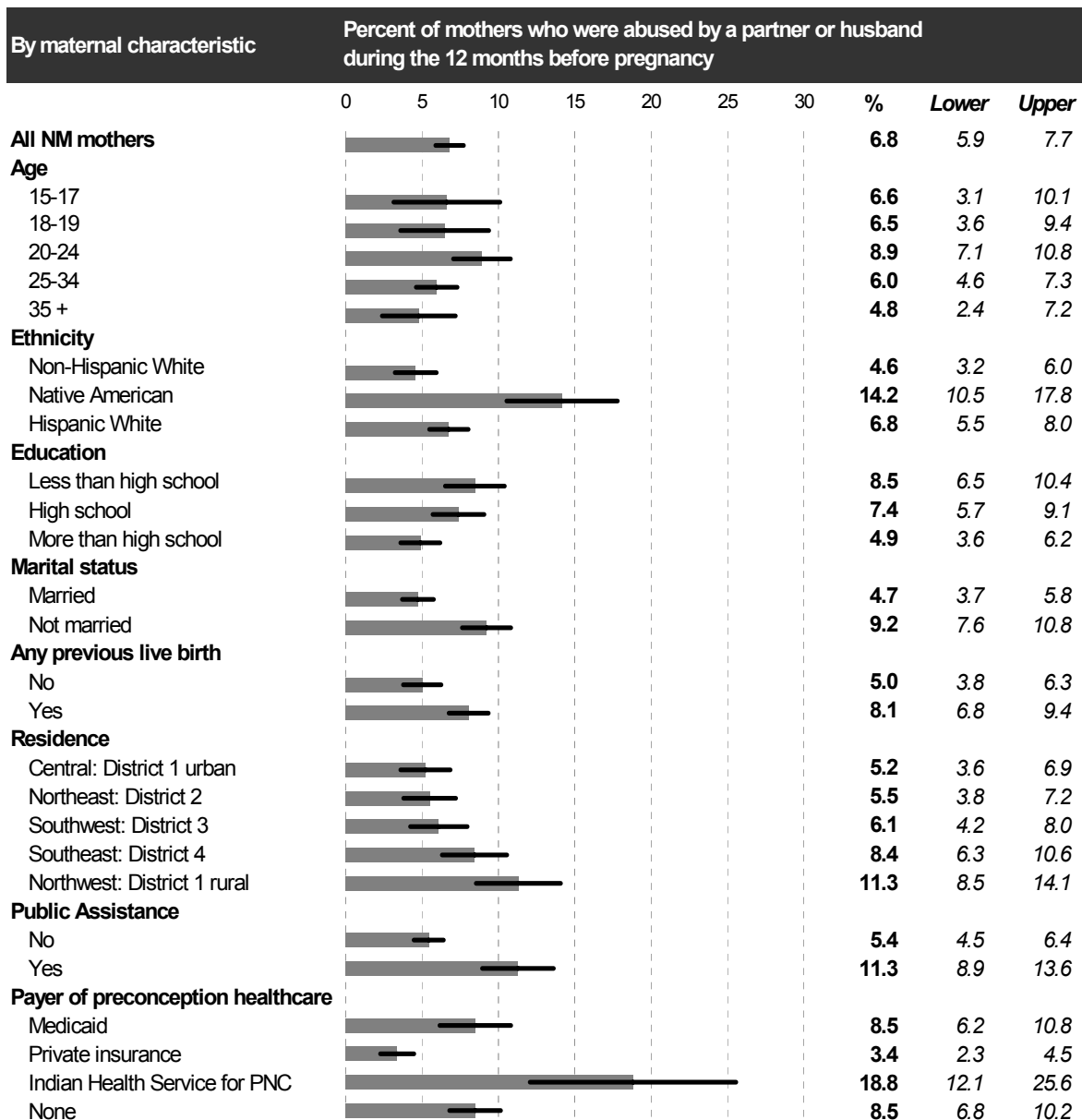
NM mothers were more likely to report being abused than other PRAMS mothers in the US, where the range was 3.0% to 9.0% during the 12 months before and 2.3% to 7.3% during pregnancy (year 2000 births).⁵ The Healthy People Objective 2010 aims for fewer than 3.3 physical assaults by a current or former intimate partner per 1,000 persons, 12 years or older.⁶

In 2002, almost 2000 new mothers (7.6% of the total) recalled being abused during the 12 months before pregnancy . During pregnancy, the rate was 5.6% . In 2001-2002, abuse during pregnancy was far more likely among women who were unmarried (8.2% v. 3.2% if married), had public assistance (10.0% v. 4.1% if without assistance) or were Native American (10.0% v. 5.9% of Hispanic whites and 3.5% of non-Hispanic whites); Findings were similar before pregnancy. Community-based groups connect law enforcement, judicial and social service agencies. Gaps in services include shelters and programs, transitional housing and vocational preparation for women; batterer's treatment programs that also address alcohol, substance abuse, and parenting issues; and children's counseling services.

Tables that detail gaps and disparities in physical abuse by a partner before and during pregnancy are found on the next pages. These data are critical to understanding what kinds of strategic planning is needed to reduce this form of family violence.

Physical abuse by a partner or husband during the 12 months before pregnancy

NM PRAMS, years 2001-2002. "Lower" and "Upper" refer to the error margin of the 95% confidence interval; a strikethrough indicates a large margin and the need to use the data with caution. Number of respondents=3161, population size=52072.

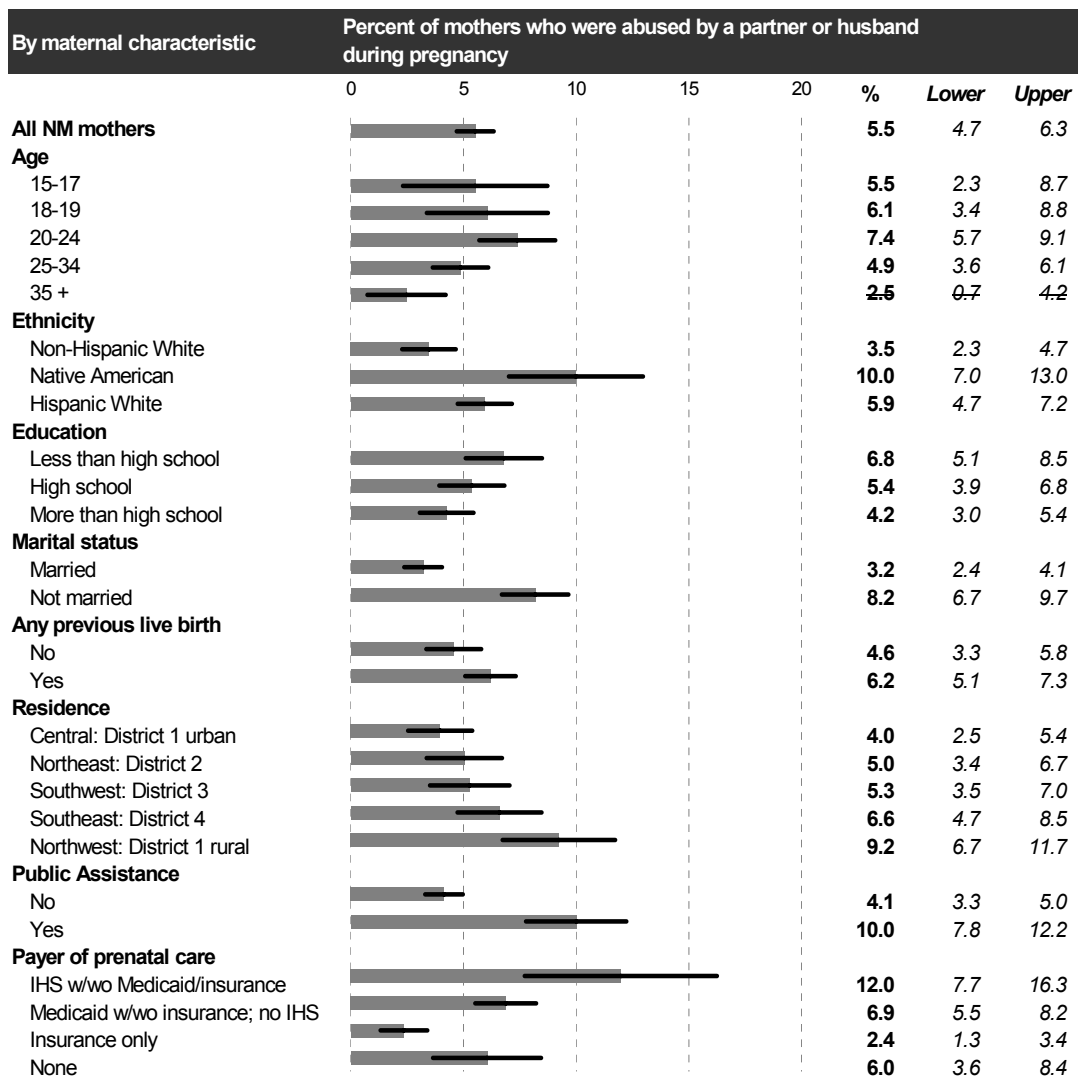


There were not many differences between physical abuse by a partner before and during pregnancy, but because the Title V MCH Program selected abuse during pregnancy as a

state performance measure, the data table is shown on the next page. This measure is directly related to measures on children witnessing violence

Physical abuse by a partner or husband during pregnancy

NM PRAMS, years 2001-2002. "Lower" and "Upper" refer to the error margin of the 95% confidence interval; a strikethrough indicates a large margin and the need to use the data with caution. Number of respondents=3161, population size=52072.



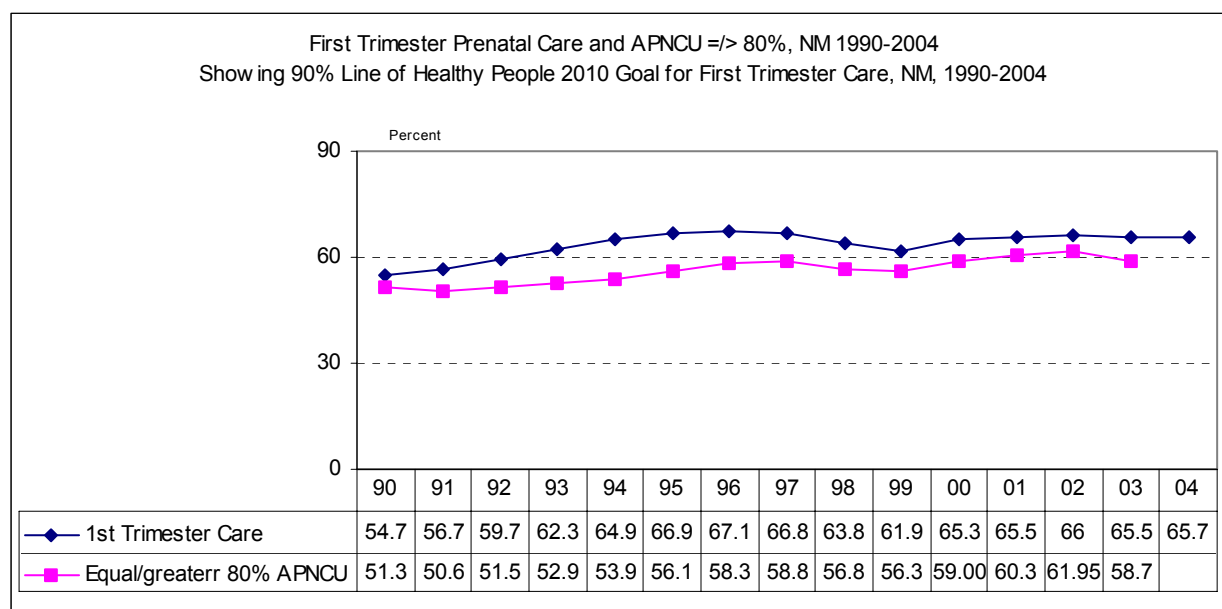
HEALTH OF PREGNANT WOMEN IN NEW MEXICO: PRENATAL CARE

The Healthy People 2010 Goal is to increase the proportion of pregnant women who receive early and adequate prenatal care beginning in the first trimester of pregnancy to 90%.

- ❖ NM continues to rank 49th in the nation for first trimester entry to prenatal care – at 65.7% in 2004 and 1.4 times lower than the nation at 76%.

Prenatal care is a unique opportunity for women and health care providers to work together to achieve optimal health – yet there is increasing evidence of the need to develop approaches to prenatal care so that it is easily accessible, sought-after and valued by the majority. And to develop innovations to reach women with special needs, such as teens in schools or women who live by cultural traditions more so than “western health care ideals.”

The use of prenatal care is associated with decreased rates of preterm birth, fetal death and low birth weight (LBW). Preterm labor and LBW are costly: a recent study estimated that total expenditures for preterm-labor hospitalization for the United States were in excess of \$820 million. Reducing publicly funded prenatal care could increase LBW, prematurity and postnatal expenses. In a recent study of undocumented immigrants, every dollar cut would increase the cost of postnatal care by \$3.33 and incremental long-term costs by \$4.63.



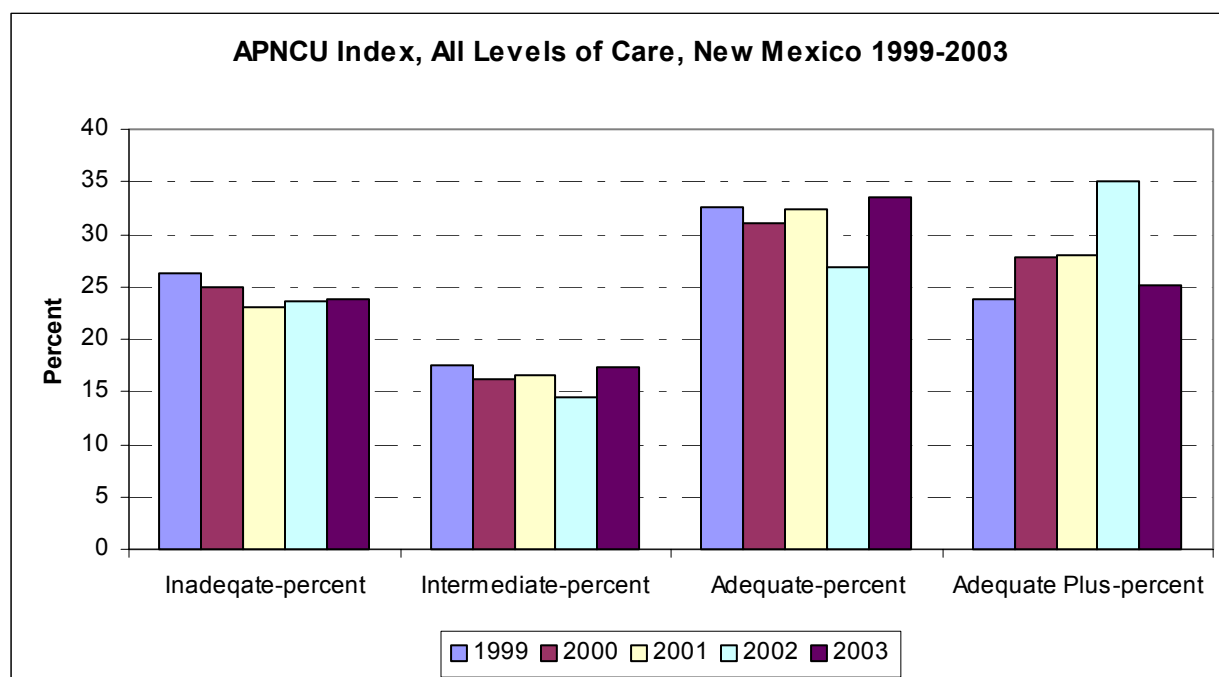
Source: New Mexico Vital Records and Health Statistics

The NM performance rose during the first six years of OBRA '89 when Medicaid eligibility became 185%, reaching an all-time high of 67.1% in 1996. New MCO arrangements made access hard for some women in period 1997-2000. The average annual increase since 1990 has been 0.97%. At this rate, and with an optimistic view, NM may be able to achieve 70% by the year 2010.

The Adequacy of Prenatal Care Utilization (APNCU) index is valuable because it adjusts the timing of the initiation of care and the adequacy of services received (ratio of observed to recommended visits), and is adjusted for gestation age of the newborn.

As with first trimester prenatal care, NM has lagged behind the US with the greatest difference at the beginning, inadequate use – NM with twice the percent of the US:

	New Mexico	United States
Inadequate Use	23%	11.3%
Intermediate Use	16.6%	14%
Adequate Use	32.3%	42.7%
Intensive or		
Adequate Plus Use	28%	31.8%






























Source: NM Pregnancy Risk Assessment Monitoring System, 1999-2003

Factors associated with inadequate utilization of prenatal care from NM PRAMS:

- ❖ Less likely among women with third party payer compared with those with no insurance
- ❖ Less likely among women with preconception care paid by insurance compared to those with neither Medicaid nor insurance
- ❖ Strongly associated with lack of child care or transportation
- ❖ Associated with women who did not want a pregnancy; had less than a high school education; were eligible and did not participate in prenatal WIC services; were unmarried; who were Native American; who had a family income under \$23,400; who reported stress of unpaid bills; and who had one previous live birth

Adequate prenatal care (APNCU or Kotelchuck Index)

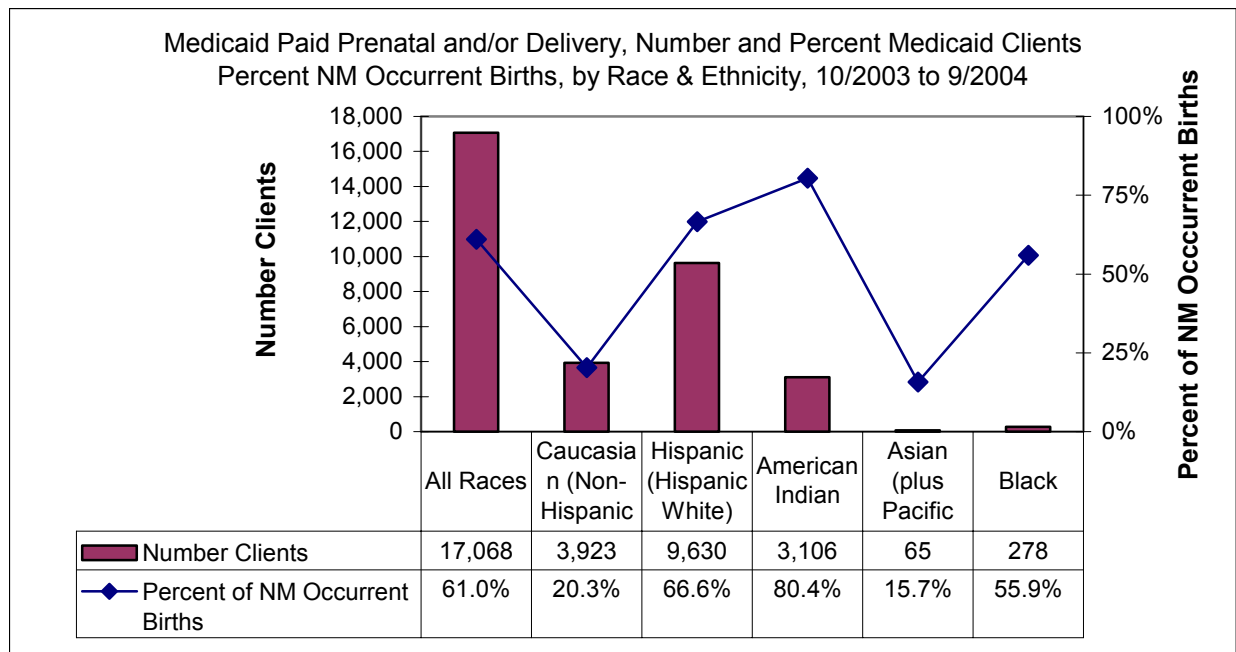
Source: NM PRAMS and Vital Records (VR), from NM residents with in-state birth, years 2001-2002. Estimates may differ from VR report. "Lower" and "Upper" refer to the error margin of the 95% confidence interval; a strikethrough indicates a large margin and the need to use the data with caution. Data available for 2979 of 3161 respondents, population=48821 of 52072.

By maternal characteristic	Percent of women with adequate prenatal care										%	Lower	Upper
	0	5	10	15	20	25	30	35	40	45	50	55	60
All NM women											32.0	30.3	33.8
Age													
15-17											30.2	22.9	37.6
18-19											26.4	21.0	31.8
20-24											33.5	30.2	36.7
25-34											33.3	30.5	36.1
35 +											29.9	24.6	35.1
Ethnicity													
Non-Hispanic White											34.8	31.6	37.9
Native American											35.0	30.0	39.9
Hispanic White											29.6	27.2	32.1
Education													
Less than high school											27.4	24.1	30.8
High school											31.9	28.8	35.0
More than high school											35.7	32.8	38.6
Marital status													
Married											33.5	31.1	35.9
Not married											30.3	27.7	33.0
Any previous live birth													
No											35.2	32.2	38.1
Yes											30.1	27.8	32.3
Residence													
Central: District 1 urban											30.9	27.4	34.4
Northeast: District 2											33.2	29.6	36.8
Southwest: District 3											31.9	28.2	35.5
Southeast: District 4											34.2	30.6	37.8
Northwest: District 1 rural											32.0	28.0	36.1
Public assistance													
No											34.2	32.1	36.2
Yes											25.1	21.8	28.5
Payer of prenatal care													
IHS w/wo Medicaid/insurance											37.7	30.9	44.5
Medicaid w/wo insurance; no IHS											30.2	27.6	32.8
Insurance only											34.3	31.2	37.4
None											29.4	24.5	34.4

Factors Associated with APNCU: In a multinomial, multivariable analysis using data from 1997-2002, other factors were associated with APNCU. The following statements apply to the model comparing inadequate with adequate utilization.

- ❖ Inadequate utilization was less likely among women with a third-party payer compared to those with no insurance; or for women with preconception care paid by insurance compared to those with neither Medicaid nor insurance.
 - ❖ Inadequate utilization was strongly associated with lack of childcare or transportation.
 - ❖ Women were also more likely to underutilize PNC if they
 - ❖ did not want the pregnancy, had less than a high school education, did not participate in prenatal WIC, were unmarried or of Native American ethnicity; or had an annual family income under \$23,400, experienced the stress of unpaid bills or had one previous live birth.
- Evaluation of Late or No Care from NM PRAMS: For years 2001-2002 combined, late or no prenatal care was associated with maternal age, ethnicity, education, marital status, residence, use of public assistance and payer of prenatal care. Adequate utilization of PNC was only associated with maternal education or use of public assistance. 59.3% ($\pm 3.4\%$) of women with late or no prenatal care said they started as early as desired. Among those who started late, the main reasons were not knowing they were pregnant (36%), lack of money or insurance (30%) or inability to get an appointment (26%).

A high proportion of prenatal care and/or delivery is paid by Medicaid.



Data Source: Medical Assistance Division, NM Human Services Department

Healthy People 2010 has a general goal to increase the percent of people who receive appropriate counseling about health behaviors. Many studies show that a health care provider's advice and counsel can be highly valued ~ even lead to improvements. In prenatal care this is even more true. The percent of women who reported that a provider talked with them about key topics in 2001-2002 is summarized:

- ❖ Most women (more than 80%) recalled talking about breastfeeding, safe medicines, postpartum birth control, tests for birth defects, management of early labor or getting an HIV test;
- ❖ fewer recalled discussing maternal alcohol use (74%), smoking (73%),
- ❖ even fewer reported discussing sensitive topics of illegal drugs (68%) or partner abuse (48%);
- ❖ finally, only 56% were counseled about use of seat belts in pregnancy although motor vehicular crash is the leading cause of death in pregnant women in NM.

Motivation to use PNC appears to be an issue, given that more than half of women with late prenatal care said they started as early as desired. The Centering Pregnancy Program can encourage pregnant women's interest in PNC. Offered in several NM sites, this approach empowers women and develops support networks through group sessions. Professionally facilitated group meetings complement standard clinical visits. Women engage in self-care activities of recording their own weight and blood pressure, estimating gestational age and discussing topics related to pregnancy, childbirth, parenting and personal growth.


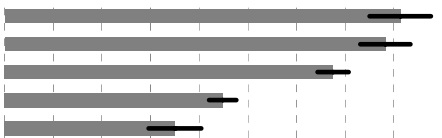

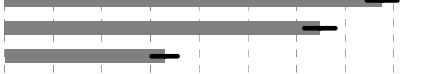

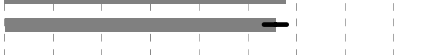
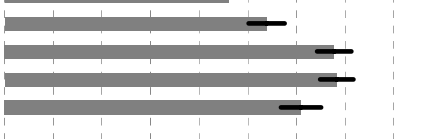
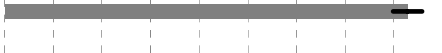

Strategies to increase access to care include supporting Certified Nurse Midwives and Licensed Midwives, who attend more than one third of the deliveries in New Mexico. Current liability insurance requirements jeopardize the availability of their services. During the winter of 2005, bills (SB5, SB292, SB419) that died in committee were introduced to cover midwives' risk insurance.

The "safety net" for uninsured women includes Medicaid, primary care clinics, NMDOH Public Health offices offering prenatal care, and a fund that pays specialty providers to care for medically indigent, high-risk women. Medicaid pays for approximately half of NM deliveries.¹³ Pregnant women whose family income is at or below 185% of poverty may apply for pregnancy-related Medicaid, which covers medical conditions related to the pregnancy, delivery, post-

partum and family planning. For pregnant women in Medicaid Category 35,¹⁴ two of the three managed care organizations (Lovelace and Molina) also provide comprehensive care. Timely prenatal care is facilitated by Presumptive Eligibility Medicaid On Site Application Assistance, which permits application for Medicaid in the provider's office or clinic. Prenatal care support services include case management for Medicaid clients through Families FIRST. The WIC nutrition program is reported to be the point of entry into prenatal care by many providers.

WIC nutrition services during pregnancy

Source: NM PRAMS and Vital Records, from NM residents with in-state birth, years 2001-2002. "Lower" and "Upper" refer to the error margin of the 95% confidence interval; a strikethrough indicates a large margin and the need to use the data with caution. Number of respondents=3161, referring to population size=52072.

By maternal characteristic		Percent of mothers with any prenatal WIC services													
		0	10	20	30	40	50	60	70	80	90	100	%	Lower	Upper
All NM mothers															
															
													56.3	54.4	58.1
Age															
															
													81.3	75.0	87.7
													78.3	73.1	83.5
													67.5	64.3	70.7
													44.8	42.0	47.7
													35.0	29.6	40.4
Ethnicity															
															
													34.4	31.4	37.4
													72.9	68.3	77.5
													67.3	64.8	69.8
Education															
															
													77.6	74.4	80.8
													64.8	61.6	68.0
													32.9	30.2	35.6
Marital status															
															
													41.4	39.0	43.8
													73.4	70.9	76.0
Any previous live birth															
															
													57.9	54.9	60.8
													55.6	53.3	58.0
Residence															
															
													46.0	42.4	49.7
													53.9	50.1	57.6
													67.8	64.2	71.3
													68.3	64.8	71.7
													60.9	56.8	65.1
Public assistance															
															
													48.1	46.0	50.2
													82.8	79.8	85.8
Payer of prenatal care															
															
													71.0	64.8	77.2
													78.3	75.9	80.6
													20.9	18.3	23.5
													68.1	63.2	72.9

The WIC Program is highly valued not only because it provides checks for healthy foods, but also for nutrition counseling and education and referrals to other services.

Characteristics of the WIC population among women who had a live birth from NM PRAMS are presented on the previous page. As will be seen immediately by the reader, WIC serves the pregnant women in most need of supportive services. As the state works to develop approaches for strengthening home visiting services, the WIC clinics may be the most effective venue to make contact with pregnant women who may benefit most from comprehensive home visiting services. WIC does receive discretionary funding related to home visiting to support breastfeeding mothers and infants.

The NM Prenatal Care Taskforce increases PNC utilization through evidence-based strategies. This group has been active in supporting midwives and in developing innovative approaches for promoting prenatal care, and improving the quality of care that women receive.

THE HEALTH OF PREGNANT WOMEN AND MOTHERS

MATERNAL MORTALITY IN NEW MEXICO

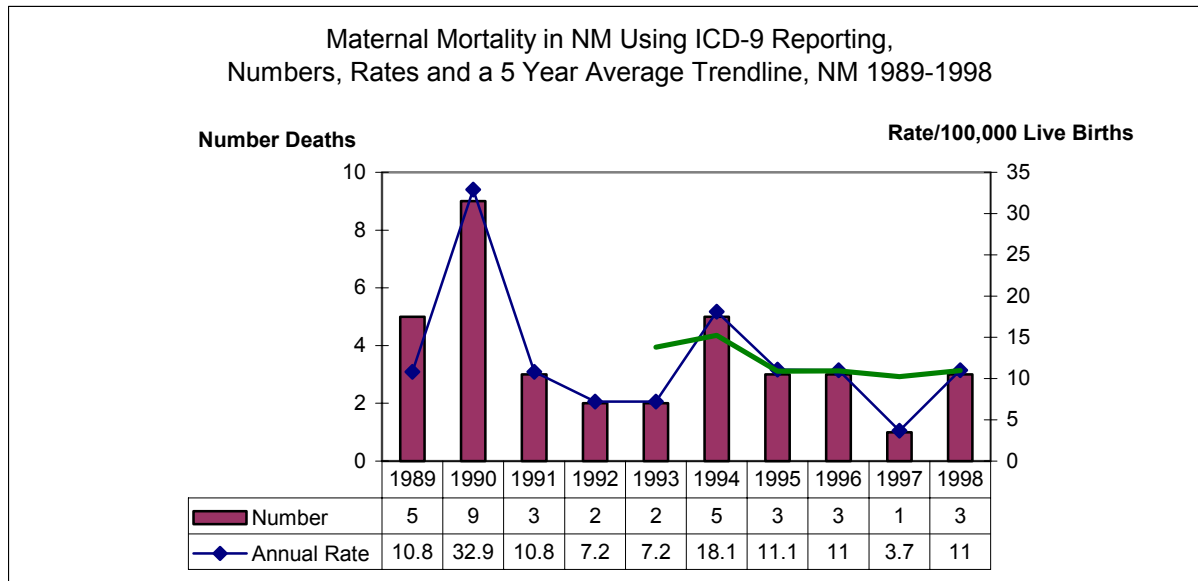
Status and trends 1990-2003 from maternal mortality reporting, NM Vital Records & Health Statistics were reviewed. The NM maternal mortality rate (MMR) has fluctuated greatly, due to the small numbers of maternal deaths in recent decades. Overall the NM rate has been higher than the national rate except for years 1987 and 1997. This presentation is in two parts because of the change in 1999 from the ICD-9 codes and MMR definition to the ICD-10 codes and new MMR definition.

Maternal Mortality, 1989-1998 Using the ICD-9 Reporting Definition: Maternal mortality statistics included deaths attributed to complications of pregnancy, childbirth and puerperium that occurred within 42 days of pregnancy, according to guidelines set forth by CDC's National Center for Health Statistics. Numbers ranged from 1-9 deaths, rates varied from year to year. 1990 was an outlier for the state with the highest rate on record since 1977.

Maternal Mortality Numbers and Rates, NM 1990-1998 Using The ICD 9 Reporting Definition										
	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
Annual Rate	10.8	32.9	10.8	7.2	7.2	18.1	11.1	11	3.7	11
Number	5	9	3	2	2	5	3	3	1	3
Number live births	27,265	27,318	27,783	27,910	27,831	27,585	26,914	27,216	26,844	27,294
5 Year Average	.	.	.	.	13.78	15.24	10.88	10.92	10.22	10.98

Source: New Mexico Vital Records and Health Statistics

Between 1989-1998 there was variability in rates; the average annual rates decreased by -2.77% from 13.78 to 10.98 per 100,000 live births.



Source: NM Vital Records and Health Statistics

Maternal Mortality, 1999-2003, Using the ICD-10 Reporting Definition:

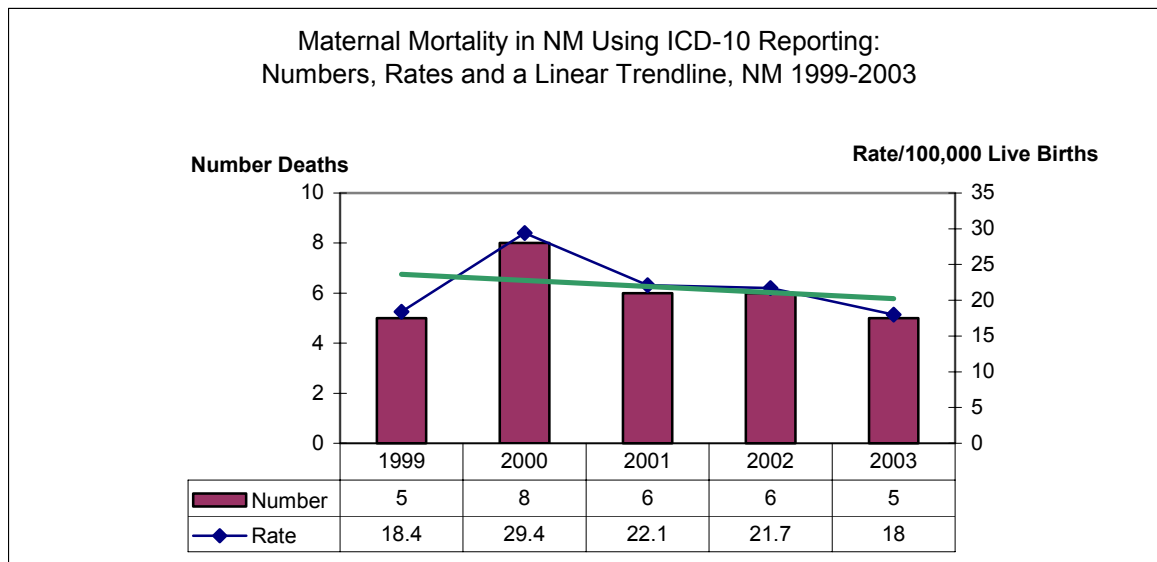
In 1999, the state shifted from the ICD-9 to the ICD-10. Deaths from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes were included in maternal mortality. ICD-10 codes applied included A34, O 00- O 95, O 98-O99. Numbers ranged from 5-8 deaths, with variability in rates due to the small numbers.

In 2002 (most current comparison data available) the NM rate of 21.7 was 2.5 times the national rate of 8.9 maternal deaths per 100,000 live births. Great caution must be used when interpreting this comparison due to the relatively small number of NM deaths and births and the disproportions in the data. There were over 4 million live births in the US in 2002; NM comprised 0.7% of the nation's live births. Of 357 maternal deaths reported in 2002 for the nation, there were 6 in NM or 1.7% of the total, 2.43 times the ratio of NM births to US births.

Maternal Mortality Numbers and Rates, NM 1999-2003, ICD-10 and Revised Reporting Definition

ICD-10	1999	2000	2001	2002	2003	5 Year Mean
Rate	18.4	29.4	22.1	21.7	18	21.92
Number	5	8	6	6	5	6
Number live births	27,133	27,206	27,101	27,708	27,799	27,389

Source: New Mexico Vital Records and Health Statistics



Source: New Mexico Vital Records and Health Statistics

The distribution of deaths by maternal age or by maternal race-ethnicity suggest that disparities in NM mirror the national profile. Of a total 17 deaths in period 2001-2003, racial differences were reported: 5 Non-Hispanic White (29.4%); 9 Hispanic White (52.9%); 0 Black and 3 Native American (17.6%). The greatest risks were among teens 15-19 (4 deaths) and women over 35 (7 deaths). Even though numbers are small, most maternal deaths are preventable and NM has used the maternal mortality review process to attempt to address reducing the risks.

MATERNAL MORTALITY REVIEW (MMR)

From 1996-February 2004, the MCH Epidemiology Program sponsored and convened the NM MMR process. The MMR committee and staff developed a summary of key issues in maternal mortality for the period 1996-2000. The data are based on deaths that occurred during pregnancy and up to 365 days after the end of the pregnancy:

- ❖ Motor vehicular crash deaths comprised 34% of all maternal deaths in the defined period
- ❖ 79% of women were not wearing seatbelts, although the report does not distinguish whether during or after pregnancy.
- ❖ 12 intentional injury deaths and one drowning were reported.
- ❖ 17 non-pregnancy related natural deaths were reported.

- ❖ 28 pregnancy related deaths were reported – 8 cardiac disease; 3 amniotic fluid emboli; 3 pulmonary emboli; 5 hemorrhage; 3 pregnancy induced hypertensive disease; 2 seizure; and one each IDDM, asthma, venous sinus thrombosis and puerperal sepsis.

In the period 1999-2003, the committee published one provider alert on placenta accreta that was published in the DOH Epidemiology Bulletin. The committee lost its staff in March 2004, no further products aimed at prevention were completed. As described in the Grant Application of 2005, the Title V Program will reassess its capacity to continue MMR.

MATERNAL MORBIDITY

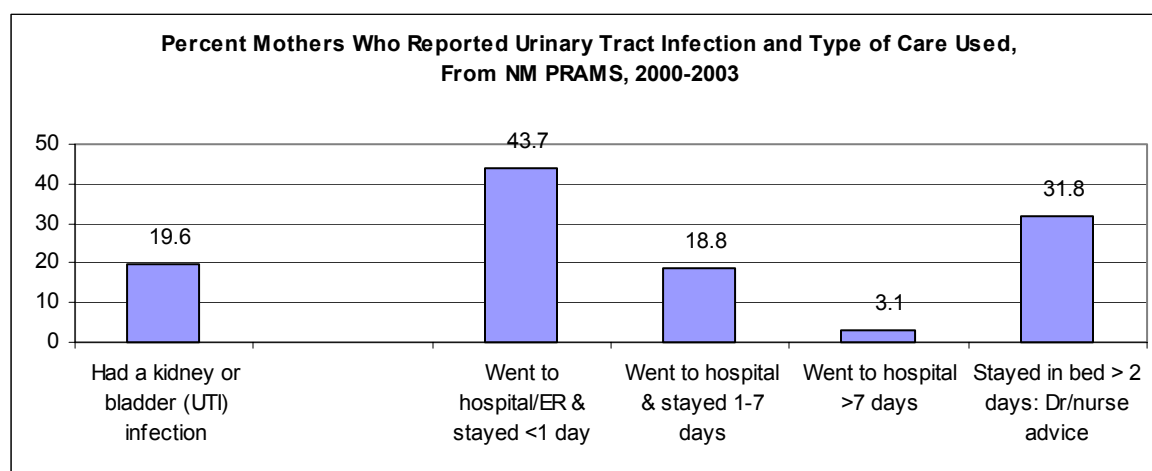
Maternal morbidity before, during and after pregnancy is a potential issue for NM. A comprehensive assessment was not done for this report, however NM PRAMS provides information about selected morbidities, as reported by the mother on the survey.

Selected Morbidity and Injury Prevalence and Estimated Total Number Affected for a 3 total Year Period 2000 to 2003, From NM PRAMS				
	%	±	Number	±
Had labor pains >3wk before due date (preterm - early labor)	28.3	1.2	29,063	1,263
Had severe nausea, vomiting, or dehydration	27.2	1.2	27,934	1,243
Had a kidney or bladder (UTI) infection	19.6	1.1	20,118	1,104
Had high blood pressure (incl. Pre-eclampsia or toxemia or had edema)	17.3	1.0	17,783	1,051
Had vaginal bleeding	14.5	1.0	14,843	989
Had high blood sugar (diabetes)	7.9	0.7	8,143	752
Said their water broke > 3wk before due date (PROM)	5.4	0.6	5,504	603
Had placenta problems (abruptio/previa)	5.3	0.6	5,446	627
Said the cervix had to be sewn shut (cerclage)	2.4	0.4	2,498	428
Were hurt in a car accident	2.2	0.4	2,288	419
The plus/minus sign shows the margin of error, derived from the 95% confidence interval				

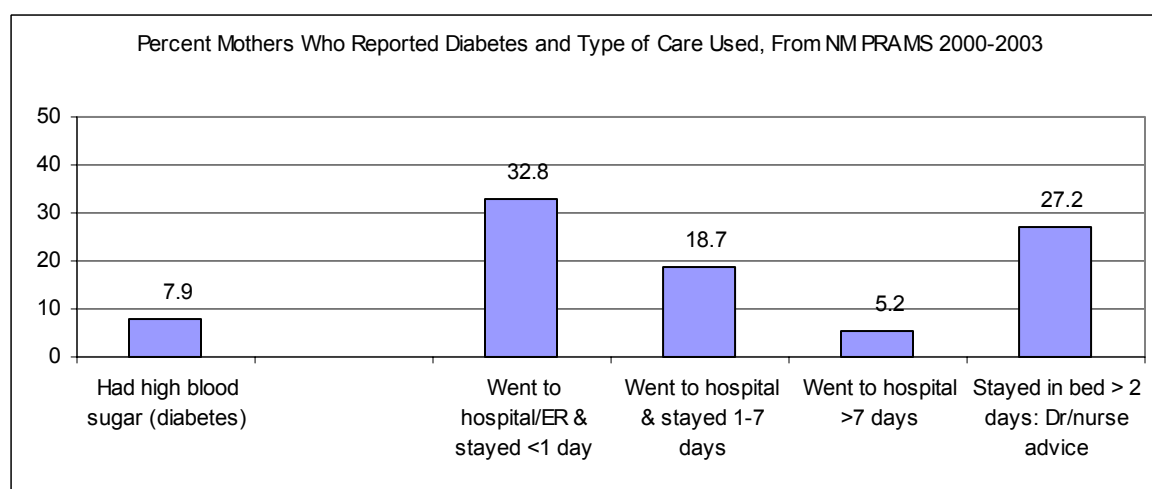
Preterm labor and low birth weight are costly: a recent study estimated that total expenditures for preterm-labor hospitalization for the United States were in excess of \$820 million. Recall that the UNM Perinatal Center estimated that 10% of women at risk of a preterm delivery transferred actually went home and delivered close to term.

Some conditions reported by PRAMS would fit the definition of an ambulatory sensitive condition – suggesting that had the woman been in prenatal care with ease of access to the provider, an emergency room or hospital admission may have been averted. Most morbidity resulted in an emergency room visit and/or bed-rest for 2 or more days. There are striking similarities in the type of care used across the three morbidities presented below.

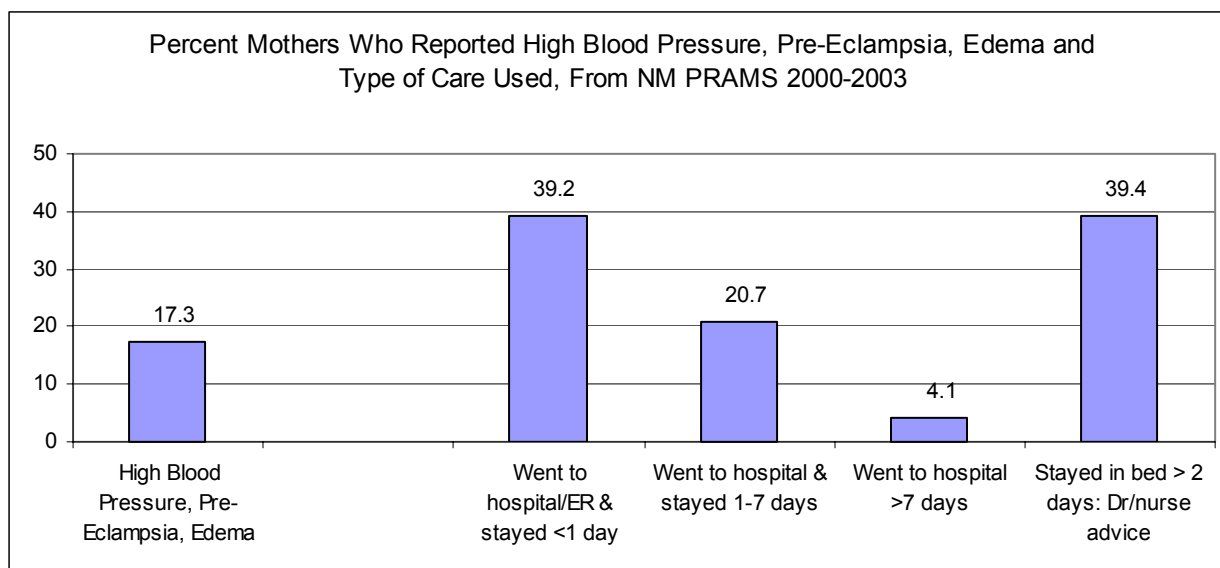
Urinary Tract Infection: Overall, 19.6% of mothers said they had a urinary tract infection, a condition that is easily treated in a physician's office however information.



Diabetes: Overall 7.9% of mothers reported having diabetes (not specified as to gestational or pre-existing – the reasons for an emergency room visit are not clear.



Hypertension – including symptoms of pre-eclampsia or edema. Overall 17.3% of mothers reported this problem. Almost 40% went to an emergency room; and a similar number were prescribed bed-rest.






























In the previous 5-year assessment period, an analysis of pregnancy morbidity was done using HIDD data by Melissa Schiff, MD of the Dept OB-GYN at UNM. That analysis suggested that many hospitalizations could be categorized as ambulatory care sensitive conditions with a need to examine access to and use of medical care by pregnant women who were hospitalized for such diagnoses as urinary tract infections, sexually transmitted diseases, and diabetic complications.

Obesity and pregnancy outcomes

The NM PRAMS Report, 2001-2002 describes risks. During pregnancy obese women have a higher risk of complications related to high blood pressure or gestational diabetes, preeclampsia and problems with delivery, including caesarean section. Even among glucose-tolerant women, prepregnancy overweight and obesity are associated with hypertensive complications, cesarean section and macrosomia (excessive birth weight, which is associated with delivery complications). Risks to the infant include being large for gestational age (with increased risk for hypoglycemia), stillbirth and early neonatal death. Maternal obesity is also implicated in birth defects such as neural tube or congenital heart defects. The risk of certain defects increases among women who are both obese and diabetic.

Preconception (excessive) weight problem

Adults 21 years or older: obese or overweight. Adolescents: overweight or at risk for overweight. See Appendix for details. NM PRAMS, years 2001-2002. "Lower" and "Upper" refer to the error margin of the 95% confidence interval; a strikethrough indicates a large margin and the need to use the data with caution. Number of respondents=3161, population size=52072.

By maternal characteristic		Percent of mothers with a preconception weight problem										%	Lower	Upper
		0	10	20	30	40	50	60	70	80	90	100		
All NM mothers												39.0	37.2	40.8
Age														
	15-17											17.4	11.5	23.2
	18-19											19.9	14.8	24.9
	20-24											37.0	33.7	40.2
	25-34											46.3	43.5	49.2
	35 +											44.7	39.1	50.3
Ethnicity														
	Non-Hispanic White											31.9	28.9	34.9
	Native American											55.2	50.1	60.3
	Hispanic White											40.5	37.9	43.1
Education														
	Less than high school											33.5	30.0	37.0
	High school											45.0	41.7	48.3
	More than high school											37.4	34.6	40.3
Marital status														
	Married											40.0	37.5	42.4
	Not married											37.9	35.1	40.6
Any previous live birth														
	No											30.4	27.6	33.2
	Yes											44.6	42.2	46.9
Residence														
	Central: District 1 urban											37.1	33.6	40.6
	Northeast: District 2											35.1	31.5	38.7
	Southwest: District 3											37.1	33.4	40.8
	Southeast: District 4											40.1	36.4	43.7
	Northwest: District 1 rural											48.3	44.0	52.6
Had public assistance														
	No											36.5	34.5	38.6
	Yes											46.8	42.9	50.8
Payer of preconception healthcare														
	Medicaid											38.6	34.1	43.0
	Private insurance											36.5	33.7	39.3
	Indian Health Service for PNC											61.6	53.3	69.8
	None											39.3	36.3	42.3

Maternal obesity is predictive of childhood overweight. The relationship between a mother's obesity and her child's risk for overweight has both biological and environmental implications. Prenatally, a woman's body composition helps determine the weight of her child from infancy through adolescence. Some studies suggest that breastfeeding may also protect against childhood and adolescent overweight. In 2002, 40% of New Mexico mothers had a weight problem before pregnancy, and 9% of all mothers had either pre-existing or gestational diabetes.

Both rates increased from 1998 when 33% had a weight problem and 7% had diabetes. In 2001-2002, forty-one percent of Hispanic women and 55% of Native American women had a pre-conception weight problem compared with 32% of non-Hispanic Whites. Among all ethnic groups, women who received public assistance were more likely to have a weight problem than women not receiving assistance (47% versus 37%). As expected, those with previous live birth were more likely to have a weight problem.

Pre-existing or gestational diabetes

NM PRAMS, years 2001-2002. "Lower" and "Upper" refer to the error margin of the 95% confidence interval; a strikethrough indicates a large margin and the need to use the data with caution. Number of respondents=3161, population=52072.

By maternal characteristic		Percent of mothers who had pre-existing or gestational diabetes				
		0	10	20	30	% Lower Upper
All NM mothers						8.1 7.1 9.1
Age						
15-17						4.0 0.8 7.2
18-19						4.9 2.2 7.7
20-24						4.6 3.2 6.1
25-34						10.1 8.4 11.9
35 +						15.4 11.4 19.4
Ethnicity						
Non-Hispanic White						5.5 4.0 6.9
Native American						14.9 11.2 18.5
Hispanic White						8.1 6.6 9.5
Education						
Less than high school						8.9 6.8 11.1
High school						7.1 5.4 8.7
More than high school						8.3 6.6 9.9
Marital status						
Married						8.5 7.1 9.9
Not married						7.7 6.2 9.2
Any previous live birth						
No						6.7 5.1 8.2
Yes						9.1 7.7 10.4
Residence						
Central: District 1 urban						7.4 5.5 9.3
Northeast: District 2						9.5 7.1 11.8
Southwest: District 3						8.6 6.5 10.8
Southeast: District 4						6.1 4.3 7.9
Northwest: District 1 rural						10.2 7.6 12.8
Had public assistance						
No						7.5 6.4 8.7
Yes						9.9 7.7 12.1
Payer of prenatal care						
IHS w/wo Medicaid/insurance						11.0 6.9 15.1
Medicaid w/wo insurance; no IHS						8.4 6.9 10.0
Insurance only						6.2 4.7 7.8
None						10.6 7.3 14.0

Women had higher rates of pre-existing or gestational diabetes when they were ages 25-34 (10%) and especially if they were ages 35 and older (15%) compared to 5% of younger women. Higher rates were also observed for women with no payer of prenatal care (11%) or for Native American women (15%).

Post-partum mental health, from “baby-blues” to serious depression, has not been evaluated and NM recognizes there is a need to develop a methodology to do this. The prevalence of major or minor post-partum depression ranges from 5 to more than 25%, depending on the assessment method, the timing of the assessment and population characteristics (Perinatal Depression, AHRQ Publication No. 05-E006-2, February 2005). The impact of depression on families and infants can be tremendous. There is a need to develop an affordable and feasible approach to estimation of this condition in NM to inform policy and resource decisions. Again, home visiting programs that use public health nurses are critical to identification and early intervention – particularly for mothers who are at high risk and somewhat socially isolated.

Additional analysis of PRAMS data may provide important insights into the morbidity profile provided above:

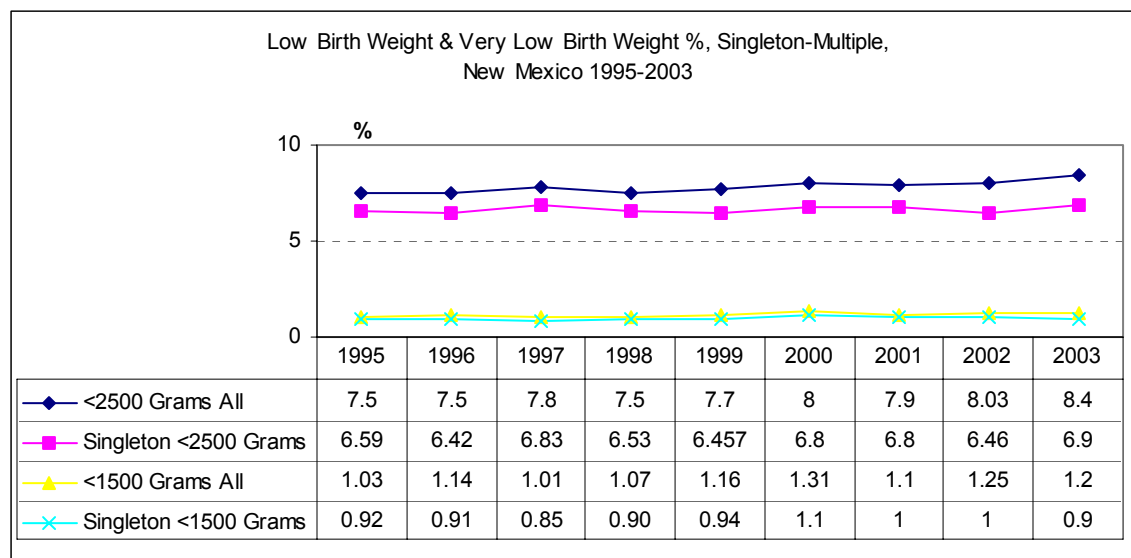
- ❖ time of entry to prenatal care,
- ❖ age & educational level of mother,
- ❖ insurance coverage during pregnancy, and
- ❖ other factors.

THE HEALTH OF NEW MEXICO INFANTS: INFANT BIRTH WEIGHT:

The Healthy People 2010 Goal is to reduce low birth weight (LBW - <2,500 grams) to no more than 5% of all live births; and to reduce very low birth weight (VLBW - <1,500 grams) to no more than 0.9% of all live births.

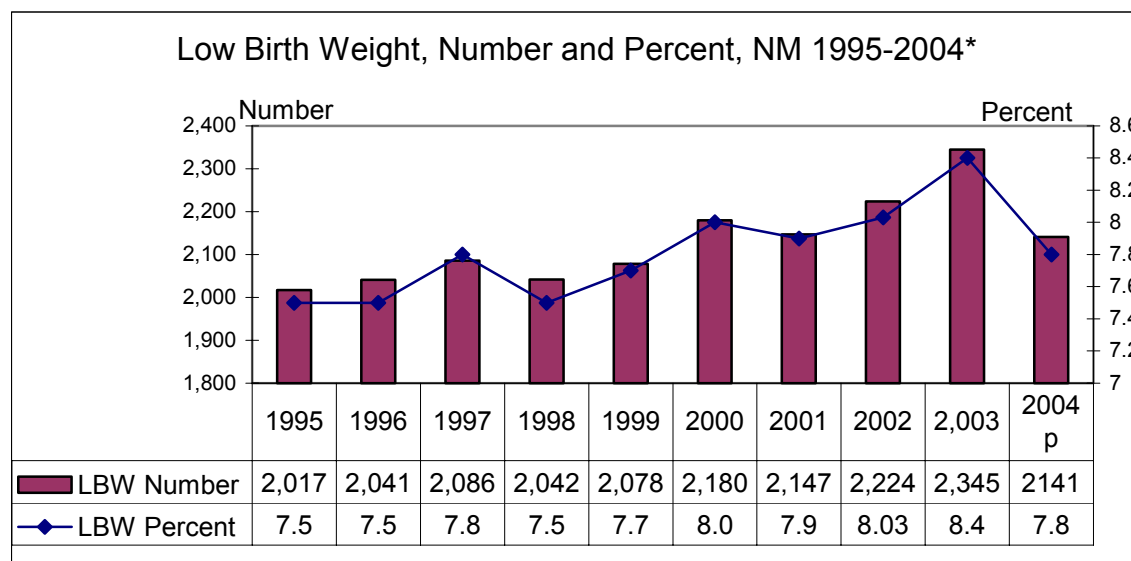
Compared to infants of normal weight, those born less than 2500 grams or 5.5 pounds are low birth weight (LBW) and at an increased risk severed perinatal morbidity, infections, and the longer term consequences of impaired development such as delayed motor and social development. Studies have shown that LBW infants were more likely to have learning disabilities and be adversely affected in the performance at school than children who were born at normal birth weight. Infants of very low birth weight (VLBW) or less than 1500 grams or 3.3 pounds have a 25% chance of dying before age 1 year. Very low birth weight infants are more likely to survive and thrive if they are born and cared for in an appropriately staffed and equipped facility with a high volume of high-risk admissions. Between 1995-2003 in NM

- ❖ the percent of LBW infants has been increasing gradually and the 3-year average 2001-03 of 8.1 was 1.6 times the Healthy People 2010 goal
- ❖ the average annual rate of increase of the percent of LBW since 1990 was 0.014%
- ❖ the percent of VLBW infants fluctuates year to year and the 3 year average of 2001-03 was 1.3 times the HP 2010 goal
- ❖ the average annual rate of increase of the percent of LBW since 1990 was 0.019%
- ❖ the reason for the increase in both LBW and VLBW is not well understood



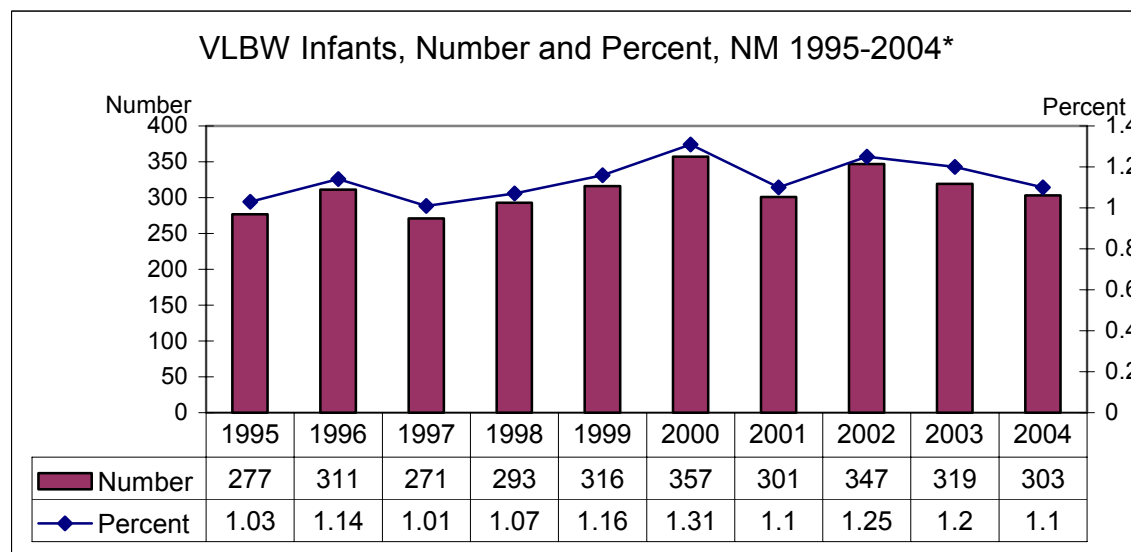
Source: New Mexico Vital Records and Health Statistics

Low Birth Weight: The numbers and rates for period 1994-2003, 2004* provisional, are increasing; the annual average percentage increase was 0 .014% for this period.



Source: New Mexico Vital Records and Health Statistics

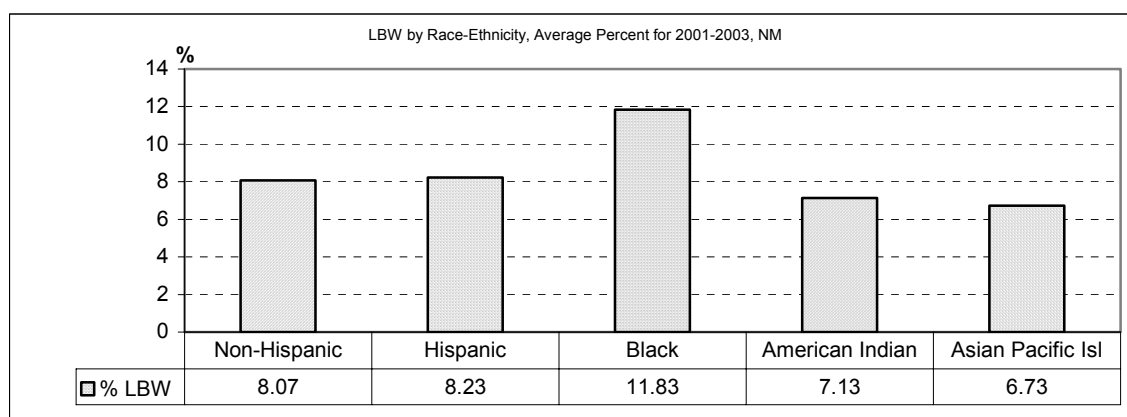
Very Low Birth Weight: The numbers and rates for 1994-2003, 2004* provisional, are increasing, the annual percentage increase was estimated at .019% for this period.



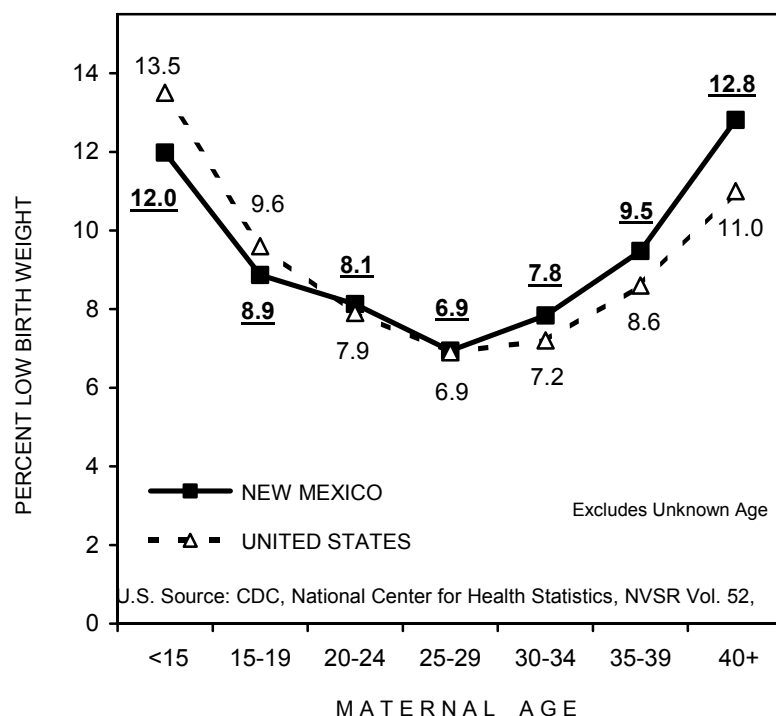
Source: New Mexico Vital Records and Health Statistics

There were disparities and interesting characteristics pertaining to the percent of LBW infants in NM. Using the 2001-2003 average percentage:

- ❖ LBW among Black infants was 1.5 times that of White Non-Hispanic infants
- ❖ LBW among Hispanic White infants was not different from Non-Hispanic White infants
- ❖ LBW among all Native Americans was 0.88 that of White Non-Hispanic Infants
- ❖ LBW among the Native American tribal groups varied with Navajo infants having less risk than all Native Americans; Pueblo and Apache infants were about the same as All Native Americans



Source: New Mexico Vital Records and Health Statistics



For period the 2001-2003 in NM and 2002 for the US, the percent of LBW by age of mother was a U-shaped curve. The 2001-03 average was 8.11; groups with rates higher than that included all teens under age 20 and mothers age 35 and older.

Infants of mothers who have no source of payment for prenatal care are at a much higher risk. This report compares US-born women with annual family

income below \$23,400 and a live birth from July 1997-December 2002. For these outcomes, Medicaid women and their infants fared much better than women with no prenatal care payer.

Factor	Mothers on Medicaid	Uninsured Mothers
Very Low Birth Weight – Infants weighing <1500 gm. (3lb. 5 oz.)	0.9%	2.8%
Low Birth Weight – Infants weighing <2500 gm. (5 lb. 8 oz.)	7.3%	9.7%
Very Premature Birth – <32 completed weeks of gestation	1.5%	6.2%
Premature Birth – <37 completed weeks of gestation	10.8%	17.3%
Hospital admissions for Newborn Intensive Care	8.7%	16.3%
Newborns hospitalized more than 6 days	6.4%	11.8%
Newborns hospitalized more than 2 months	0.1%	1.0%
Timely Prenatal Care	64.0%	42.5%

Prepared 2005 Jan.11 by Ssu Weng, tel. 476 8892, ssu.weng@doh.state.nm.us NM Pregnancy Risk Assessment Monitoring System* 8872 in-state births to NM residents, July 1997-Dec. 2002

Birth weight

Uninsured mothers were more likely than Medicaid mothers to deliver an infant weighing under 400 grams: 2.8% [1.4,5.3] v. 0.9%[0.7,1.2].

High birth weight, which places infants and mothers at risk, was also more likely among uninsured 7.7% [4.9,11.7]than Medicaid 5.5% [4.8,6.3] mothers.

The percentage of mothers delivering an infant weighing 401-2499 grams were 9.7%[7.2,13.0] for uninsured v. 7.3%[6.6,8.0] for Medicaid mothers (these estimates overlap).

Premature birth before 37 completed weeks of gestation occurred among 17.3% 12.2,23.9] of uninsured and 10.8%[9.6,12.0] of Medicaid mothers.

Birth before 33 weeks is even more costly; 6.2% [3.8,10.1] of uninsured mothers and 1.5% [1.2,1.9] of mothers paid by Medicaid delivered this early.

Admission to newborn intensive care occurred among 16.3%[11.5,22.5] of uninsured and 8.7% [7.7,9.9] of mothers paid by Medicaid.

Newborn hospitalization exceeded 6 days for 11.8% [8.1,16.9] of uninsured v. 6.4% [5.5,7.4] of Medicaid mothers. At 2 to 6 months after delivery, 1.0%[0.3,3.8] of uninsured mothers' infants v. 0.1% [0.0,0.1] of Medicaid mothers' infants remained in the hospital.

Timely prenatal care was much less likely among uninsured 42.5% [34.4,50.9] than Medicaid 64.0% [61.9,66.1] women.

Uninsured women might enter prenatal care on time if they had financial access:

47.4%[39.0,56.0] said they did not start as early as they wanted, compared with 29.9% [28.0,31.9] of Medicaid women.

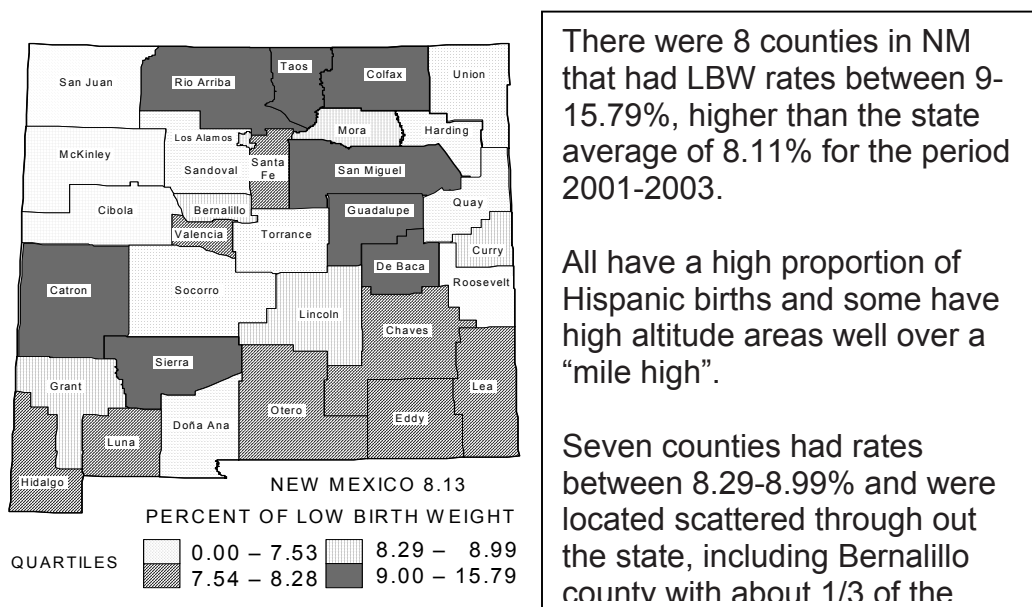
The median treatment cost of delivery for very low birthweight infants (<1500 grams or <3 pounds) is almost \$50,000, ranging from \$32,000 for infants weighing 1251-1500 grams to almost \$90,000 for infants at 501-750 grams. This is more than \$1,000 per day, with a median length of stay of 49 days (Rogowski 1999). Low birth weight can account for 10% of all health care costs for children (Lewitt et al, 1995).

LBW infants include pre-term infants, infants with intrauterine growth retardation and infants of multiple gestations. While factors that actually cause preterm labor are less understood; those that are associated with prematurity and low birth weight include

- Maternal age, both very young under 20 years and older than 34 years
- Poverty
- Smoking and substance use
- Multiple births (twins or higher)
- A previous preterm birth or spontaneous abortion
- Low pre-pregnancy weight
- Inadequate maternal nutrition & prenatal weight gain
- Untreated infections including STDs or other vaginal infections and destructive periodontal disease
- Ongoing, severely stressful living associated with the burdens of low socioeconomic status and racism (increasingly recognized as predisposing to preterm delivery)
- No prenatal care, late entry to prenatal care

Strategies and services to reduce preterm delivery and intrauterine growth retardation are comprehensive and focused: prenatal care, prevention of smoking, alcohol and substance abuse, screening and treatment for gingivitis, vaginitis, sexually transmitted diseases and urinary tract infections, nutrition education, nutrition supplementation for low income women, decreasing racism, comprehensive health care for pregnant women, cultural competence in providers and others, reduction of poverty, domestic violence, supportive employment policies, avoidance of

toxic substances at work and elsewhere, education and support to avoid overexertion and elevated core temperatures, sex education and support for avoidance of unplanned pregnancy.



The perinatal periods of risk (PPOR) process could help NM to pinpoint interventions to address not only low birth weight but also infant mortality. PPOR findings from vital records files could be enhanced by the newly produced NM PRAMS estimates for risks associated with these outcomes.

LOW BIRTH WEIGHT BIRTHS (<2500 grams)
NUMBER AND PERCENT BY COUNTY OF RESIDENCE
NEW MEXICO RESIDENT LIVE BIRTHS 2001-2003

	COUNTY	2003		2002		2001	
		No.	%	No.	%	No.	%
	NEW MEXICO	2,345	8.4	2,224	8.0	2,147	7.9
	CIBOLA	42	10.2	25	7.0	35	8.0
	BERNALILLO	778	9.0	708	8.1	671	8.0
	MCKINLEY	119	8.6	116	8.7	128	9.7
1	SAN JUAN	145	7.4	134	6.8	116	5.9
	TORRANCE	13	7.3	11	6.3	13	6.3
	SANDOVAL	93	7.3	96	7.3	103	7.9
	VALENCIA	67	6.7	77	8.1	85	8.5
	COLFAX	23	15.2	20	11.7	18	10.5
	SAN MIGUEL	38	11.1	48	12.2	42	11.1
H	TAOS	42	11.0	40	11.4	29	7.4
E	RIO ARriba	65	9.4	59	8.6	70	10.2
A 2	SANTA FE	154	9.3	126	7.8	107	7.0
L	MORA	4	9.3	6	13.0	2	3.8
T	LOS ALAMOS	10	5.5	19	9.5	19	11.2
H	UNION	2	3.7	4	8.5	3	7.0
	HARDING	0	0.0	0	0.0	0	0.0
D	SIERRA	15	12.6	10	9.8	5	4.8
I	HIDALGO	8	12.3	3	4.9	5	7.1
S	GRANT	34	10.1	30	7.7	30	7.7
T 3	LUNA	36	9.2	38	9.5	21	5.3
R	OTERO	72	8.3	62	7.0	64	7.6
I	DOÑA ANA	223	7.0	240	7.8	236	7.9
C	SOCORRO	13	6.0	9	4.3	20	8.3
T	CATRON	1	5.0	4	16.7	2	7.7
S	DE BACA	2	11.1	2	10.0	5	26.3
	CURRY	85	9.9	65	7.8	67	8.8
	GUADALUPE	4	9.5	5	7.5	6	10.7
	LINCOLN	21	9.3	21	9.6	15	7.1
4	LEA	84	8.8	78	8.6	67	7.4
	CHAVES	74	8.0	81	8.3	71	8.1
	QUAY	8	7.8	7	6.7	7	6.2
	EDDY	55	7.5	53	7.2	67	8.6
	ROOSEVELT	15	4.8	27	8.4	18	6.1

NOTE: Percents based on less than 20 events may be statistically unreliable – interpret with caution. From NM VRHS Annual Report, Table 2.6

HIGH BIRTH WEIGHT (HBW) OR BIRTH WEIGHT 4,000 GRAMS OR GREATER

In 2003, 6.1% of NM resident births were HBW, somewhat lower than the 2002 US estimate of 9.2%. For NM, 6.1% translates to about 1,700 babies. HBW infants are at an increased risk for health problems. Maternal overweight or obesity and maternal diabetes are associated with HBW outcomes. For period 1998-2002, NM PRAMS found that:

- ❖ 36.5% of mothers had a high pre-pregnancy BMI
- ❖ 7.6% of mothers had diabetes

The NM PRAMS 2001-02 Surveillance Report summarized the key issues related to mothers whose infants are at risk: During pregnancy obese women have a higher risk of complications related to high blood pressure or gestational diabetes, preeclampsia and problems with delivery, including caesarean section. Even among glucose-tolerant women, prepregnancy overweight and obesity are associated with hypertensive complications, cesarean section and macrosomia (excessive birth weight, which is associated with delivery complications). Risks to the infant include being large for gestational age (with increased risk for hypoglycemia), stillbirth and early neonatal death. Maternal obesity is also implicated in birth defects such as neural tube or congenital heart defects. The risk of certain defects increases among women who are both obese and diabetic. An example of a discussion briefing used by the Prenatal Care TaskForce is shown here, to illustrate the kinds of issues that are being addressed by that task force.

Costs- Perinatal Care: Nearly four million babies are born in the United States each year. Many of the high costs associated with poor pregnancy outcomes are preventable and unnecessary.

Delivery Costs:

- Costs for complicated births range from \$20,000 to \$400,000 per baby, compared to about \$6,400 for a "normal" uncomplicated delivery (Laman and King, 1994).
- Some complicated pregnancies require that the newborn be delivered by cesarean section. Cesarean delivery costs an average of \$11,450 in comparison to \$7,090 for an uncomplicated vaginal delivery (Mushinski, 1998).
- Among the 20 states with at least 150 uncomplicated cesarean births (83% of total births), average total charges ranged from \$14,470 in New York to lows of \$8,820 in Ohio and \$8,870 in Tennessee in 1996. Total charges differed by as much as 64% among the study states (Mushinski, 1998).
- Vaginal births after a previous cesarean (VBAC) in the United States costs an average of \$7,730 (Mushinski, 1998).

An overview of costs for two leading contributors to infant mortality and morbidity (birth defects and prematurity/low birthweight) in the United States are described below:

Birth Defects

- Birth defects can result in high costs in human suffering, medical costs, non-medical costs for special education, rehabilitation, and other services.
- The estimated lifetime costs for 18 of the most clinically significant birth defects in the United States were \$8 billion in 1992 (Waitzman et al., 1994).
- The lifetime costs of specific birth defects ranged from \$75,000 to \$503,000 per new case. Conditions with the highest costs per case include those with high levels of long-term activity limitations: cerebral palsy (\$503,000), Down syndrome (\$451,000), and spina bifida (\$294,000).

Low Birthweight/Prematurity

- Babies born too small can require increased hospital and provider resource, including time in a neonatal intensive care unit (NICU) at a cost ranging from \$1,000 to \$2,500 per day (Krebs, 1993). A severely ill newborn may spend several weeks or months in a NICU depending on the complexity of the health problem.
- The median treatment cost of delivery for very low birthweight infants (<1500 grams) is almost \$50,000, ranging from \$32,000 for infants weighing 1251-1500 grams to almost \$90,000 for infants 501-750 grams. This is more than \$1,000 per day, with a median length of stay of 49 days (Rogowski, 1999).
- Low birthweight accounts for 10 percent of all health care costs for children (Lewitt et al., 1995).
- Health care, education, and child care for the 3.5 to 4 million infants and children from birth to 15 years born low birthweight cost between \$5.5 and \$6 billion more than they would have if those children had been born at a normal birthweight.

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HIGH RISK MOTHERS AND NEONATES: ENSURING THAT HIGHER RISK MOTHERS AND NEWBORNS DELIVER AT APPROPRIATE LEVEL HOSPITALS

NATIONAL PERFORMANCE MEASURE 17: The percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

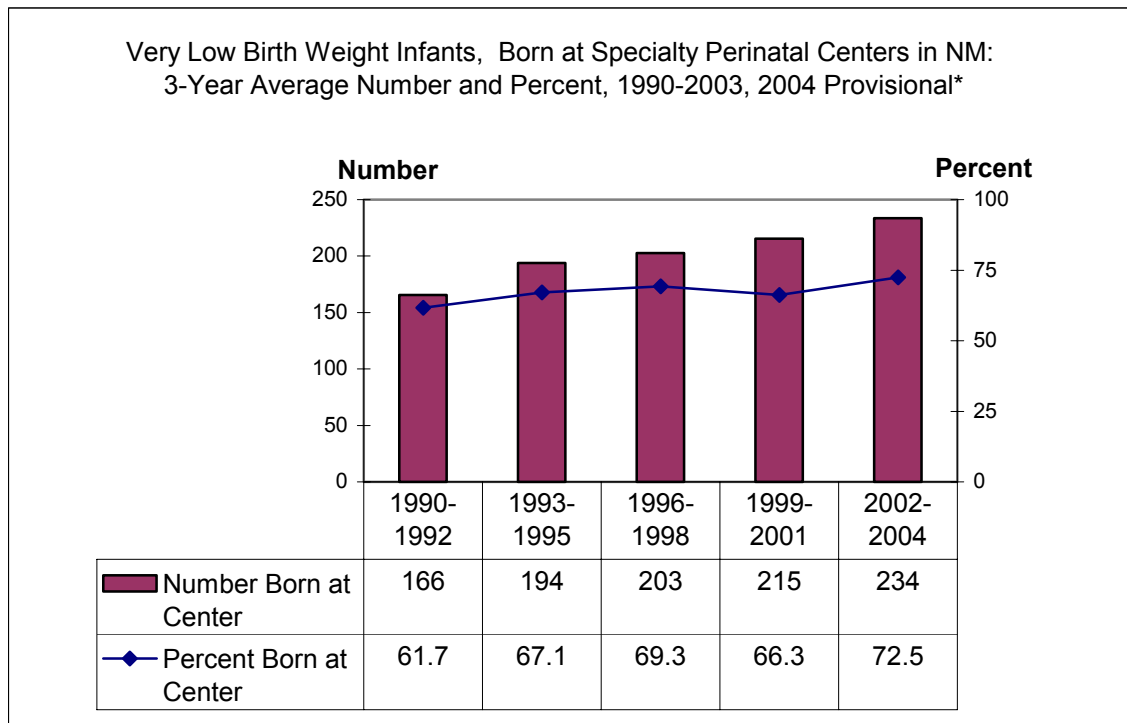
The Healthy People 2010 Objective is to increase the proportion of VLBW infants that are born at a Level III or sub-specialty perinatal center from 73% in 1986-97 to 90% by 2010. The Title V MCH Block Grant guidelines direct states to monitor, assess and address needs related to high risk pregnancies and deliveries, with focus on the needs of low birth weight (LBW) and very low birth weight (VLBW) infants.

VLBW infants are more likely to survive and thrive if they are born and cared for in an appropriately staffed and equipped facility with a high volume of high-risk admissions. Perinatal High Risk Facilities and Systems in NM:

- ❖ There are two “level III” tertiary centers for maternal-fetal and neonatal care, UNM and Presbyterian in Albuquerque
- ❖ UNM conducts maternal-fetal medicine outreach clinics Cuba, Dulce, Hatch, 2 sites in Las Cruces, Socorro, Silver City, Farmington, Roswell, Taos, Alamogordo, Gallup and 2 sites in Albuquerque
- ❖ In 2003 there were 291 very low birth weight infants; and 75.9% or 221 were delivered at one of the two level III tertiary centers.

Since 1990 the state’s performance has improved from a 1990 low of 57% to the present level over just over 70%. The perinatal center at UNM has a perinatology hotline for consultations and assists in arranging transports from rural hospitals. In 2001, key factors reported by the two perinatal centers included hospital barriers – some decline transfer to Albuquerque centers; in the southeastern part of the state, hospitals prefer to use perinatal centers in Lubbock and El Paso, both in Texas. The high altitude weather in NM (the northern part of the state is over 5,280 or “mile high”) presents special problems for fixed-wing aircraft and helicopters. In other areas, high winds >30 knots are

prohibitive for safe transfer. Some rural areas do not have paved runways; in some rural areas, runway hazards include no lights and animals grazing on the runway.



The UNM perinatal center works to build relationships and systems through education of providers and consultations. The UNM perinatal center reported that 10% of maternal transfers result in a delivery; the majority receive specialty care and go on to deliver at term.

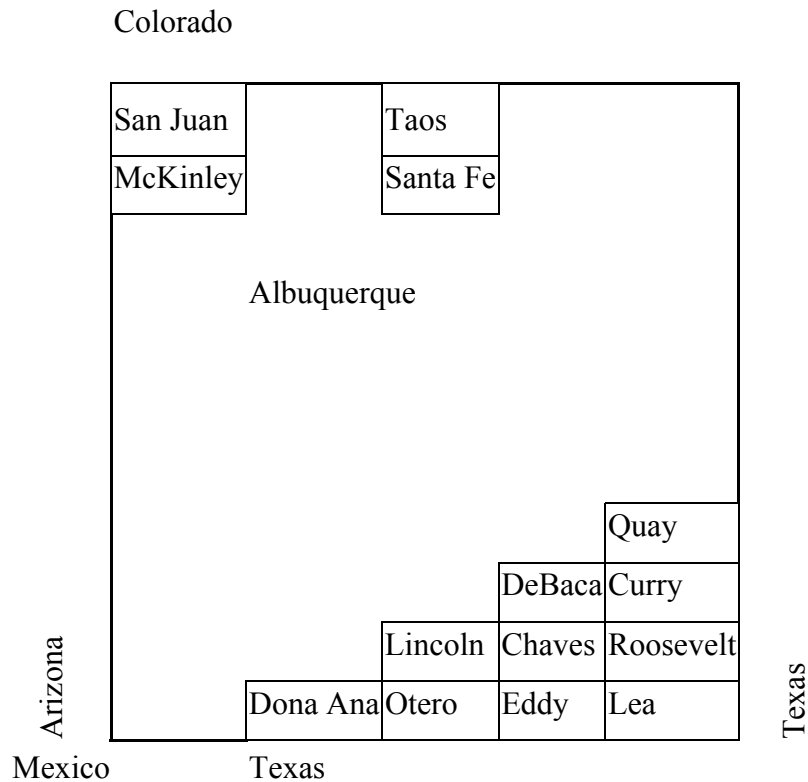
New Mexico Resident VLBW Births by State of Birth and Tertiary Status

	90-92	93-95	96-98	99-00	Total
Total Born in other states	70	78	80	73	301
Total Born in NM	734	731	787	600	2852
- Total Born in Tertiary (Level III) Centers	494	516	580	465	2055
- % Tertiary	67.3	70.6	73.7	77.5	72

*Tertiary status is available only for those born in NM

Between 1990-2000, there were 301 VLBW infants of NM resident mothers who were transferred from the county of their mother's residence to an out of state hospital, before or after delivery. The majority were transferred from southern and south-eastern counties to Texas; a few others were transferred to Colorado or Arizona.

Schematic: County of Mother's Residence of Infants Transferred
to Out of State Hospitals, 1990-2000



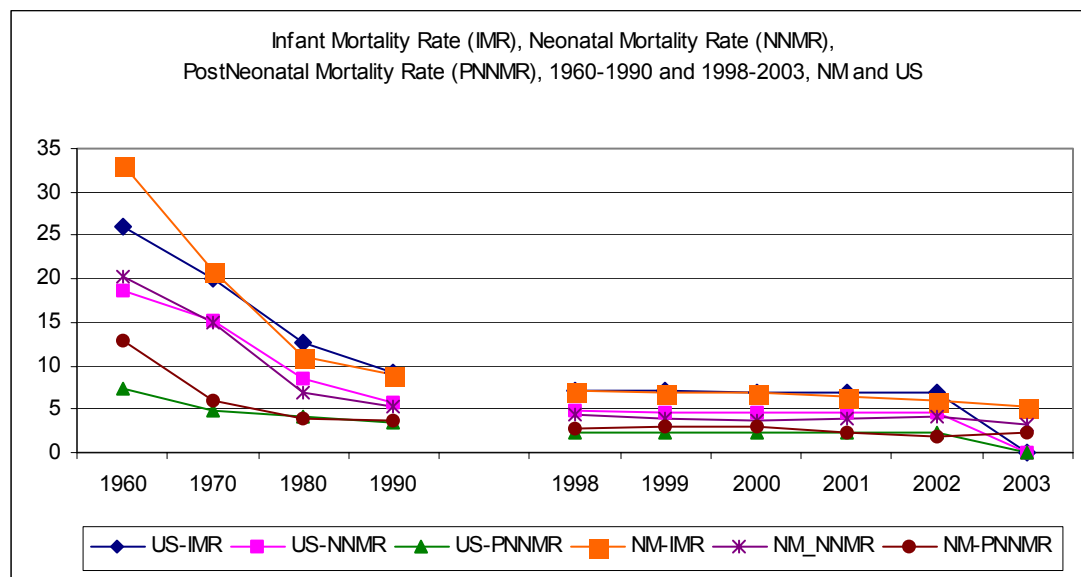
There is a long history in NM of poor access to prenatal care and delivery for low income – some migrant workers or immigrants – in the southeastern corner of the state.

Agenda for Assessment 2005-2009: There is a need to continue consultation with the perinatal centers in Albuquerque to understand the present situation. There is also a need for an evaluation of the outcome of live births that requires the linked birth – death file; the most current linkage was completed for 2000 births. In the coming five year period, the Title V MCH program will work with NM VRHS to evaluate the linked file for this indicator. The most recent analysis of infant mortality using the linked birth – death file was for years 1997-1999 and did not include this indicator.

INFANT MORTALITY AND PERINATAL MORTALITY

Infant mortality is a critical indicator of a state's wellbeing. The Healthy People 2010 goal is to reduce the infant mortality rate (IMR) to 4.5 per 1,000 live births; the neonatal mortality rate to 2.9 per 1,000 live births; and the post-neonatal mortality rate to 1.5 per 1,000 live births.

The NM infant mortality rate (IMR) – as well as the neonatal and postneonatal mortality rates – have been at or lower than the national rate since 1980 with the exception of 1994.

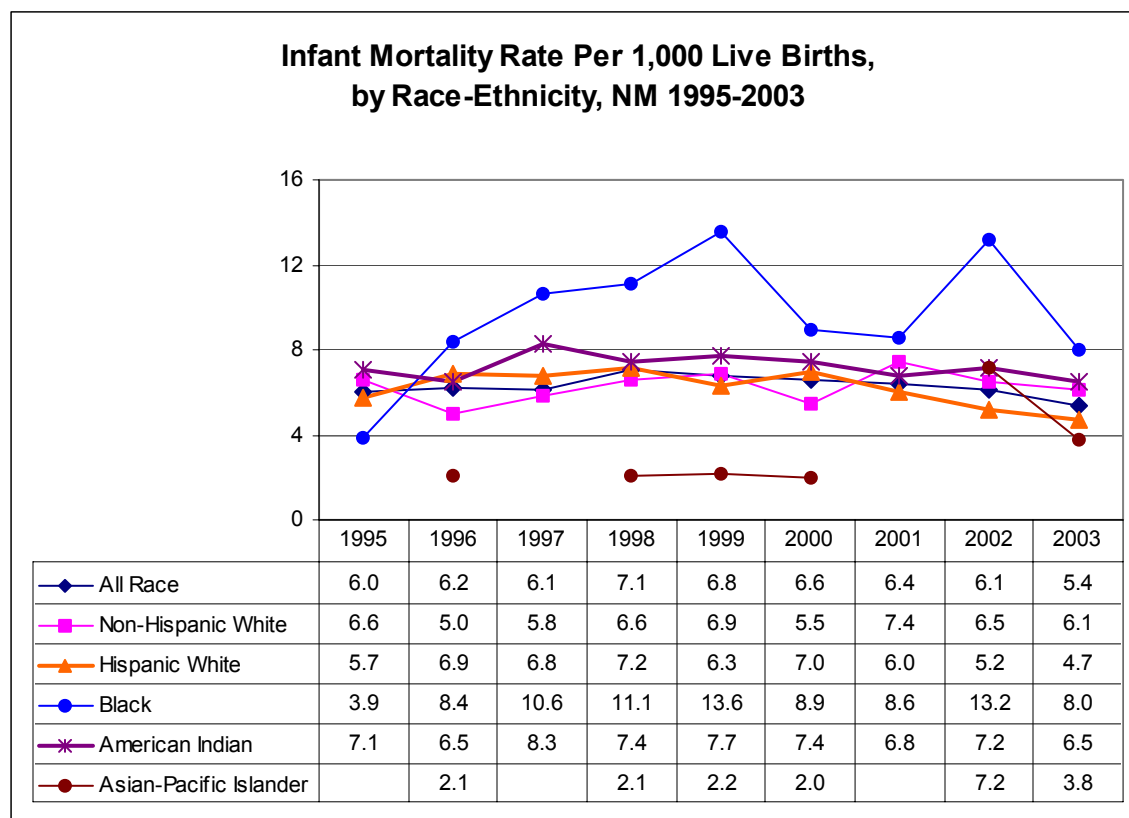


RATES

Infant Mortality Rates, Dicennial 1960-1990 and Annual Rates 1998-2003										
	1960	1970	1980	1990	1998	1999	2000	2001	2002	2003
US	26	20	12.6	9.2	7.2	7.1	6.8	6.8	7	NA
New Mexico	33.2	21	11	8.9	7.1	6.8	6.8	6.4	6.1	5.4
Neonatal Mortality Rates, Dicennial 1960-1990 and Annual Rates 1998-2003										
US	18.7	15.1	8.5	5.8	4.8	4.7	4.6	4.5	4.7	NA
New Mexico	20.2	15	7	5.2	4.3	3.9	3.7	4	4.2	3.2
Post-Neonatal Mortality Rates, Dicennial 1960-1990 and Annual Rates 1998-2003										
US	7.3	4.9	4.1	3.4	2.4	2.3	2.3	2.3	2.3	NA
New Mexico	13	6	4	3.7	2.8	2.9	2.9	2.4	1.9	2.2

Source: New Mexico Vital Records and Health Statistics

INFANT MORTALITY IN NM, BY RACE AND ETHNICITY:



Source: New Mexico Vital Records and Health Statistics

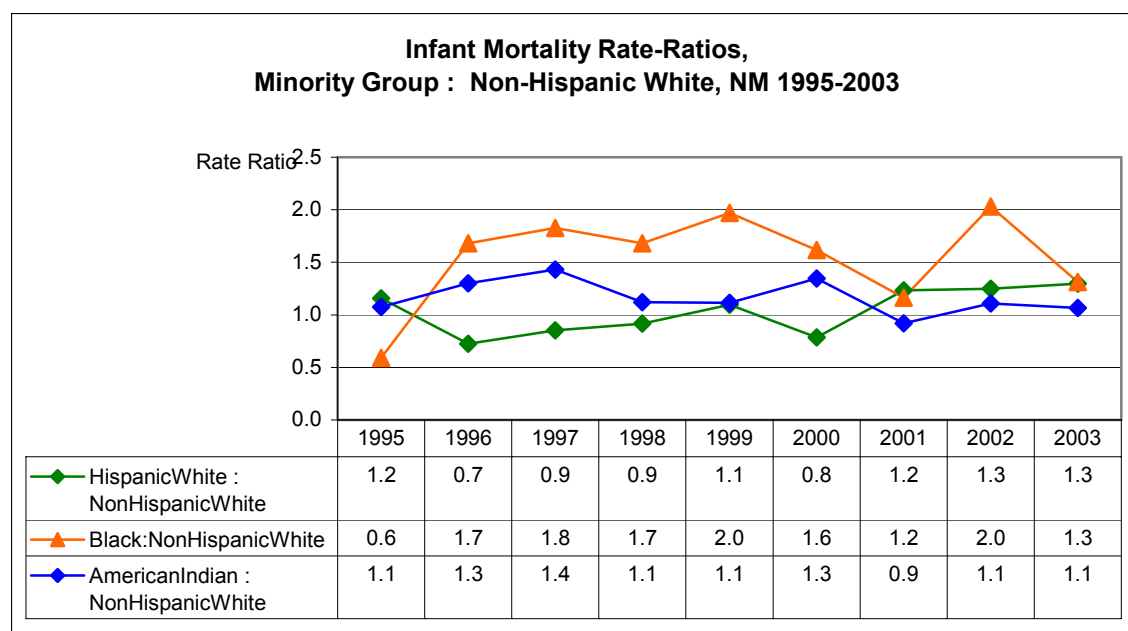
In 1995-1997, the rate was between 6-6.2. Since 1998 the IMR decreased from 7.1 per 1,000 live births to an all time low of 5.4 in 2003. Between 1995 and 2003, 2004 provisional, the 3-year average rate of decrease was 0.3%. Reducing infant mortality rates will require a combination of many complex, inter-related factors:

- ❖ The causal pathway for the leading causes, congenital malformations and complications of low birth weight are complex with many unknown factors at this time
- ❖ Focusing known prevention – folic acid supplementation, supportive treatment to reduce substance use including alcohol, drugs and smoking cessation, preconceptional health care including treatment of STDs and vaginal infections, and promoting infant sleep position (”Back to Sleep”) are well known, and could reduce mortality.
- ❖ These interventions are critical not only to reduce infant mortality, but to improve maternal and infant health outcomes.

Rate-Ratios, Minority Groups Compared to White Non-Hispanic, 1995-2003

In the next table a rate-ratio more than 1.0 indicates a higher mortality rate for the group as compared to White Non-Hispanic infants; a rate below 1.0 indicates a lower mortality rate for the group as compared to White Non-Hispanic infants..

- ❖ The mortality rate for Hispanic white infants was 1-1.3 times higher, in some years better than Non-Hispanic Whites
- ❖ The rate for Black infants was 1-2 times higher
- ❖ The rate for American Indians was 1-1.3 times higher



Source: New Mexico Vital Records and Health Statistics

Reducing these disparities requires attention to barriers of access to care and the need for culturally appropriate health services for Black, Native American and Hispanic mothers. In 2005 the CDC website urges states to develop networks between health care experts and minority communities to encourage healthy behaviors by pregnant women and parents of infants. At the same time, there is a continued need for NM health care providers in private and public sector, to become more acute in their sense of what is culturally relevant care – highly critical amongst the gatekeepers who determine eligibility for care or who are the first to greet a woman into the health care environment.

Neonatal Mortality and Post-Neonatal Mortality: The Healthy People 2010 goals are to reduce the neonatal mortality rate to 2.9 per 1,000 live births; and the post-neonatal mortality rate to 1.5 per 1,000 live births.

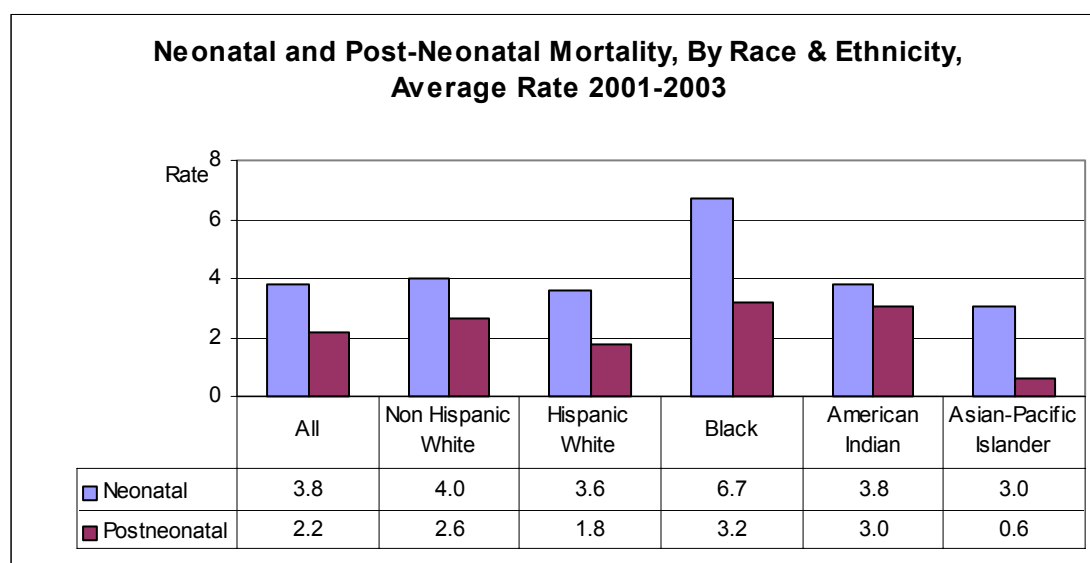
The leading causes of neonatal mortality in NM, 2001-2003 were

- ❖ Disorders related to length of gestation and fetal nutrition
- ❖ Congenital anomalies, deformations and chromosomal abnormalities
- ❖ Maternal factors and complications of pregnancy, labor and delivery

The leading causes of postneonatal mortality in NM, 2001-2003 were

- ❖ Sudden infant death syndrome
- ❖ Congenital anomalies, deformations and chromosomal abnormalities
- ❖ Later effects of disorders related to length of gestation and fetal nutrition

The rates in NM are above the 2010 goals – 2.9 for neonatal mortality and 1.5 for post-neonatal mortality, and vary by race and ethnicity.



Source: New Mexico Vital Records and Health Statistics

The study “Infant Mortality in the State of New Mexico, Linked Births – Infant Deaths, 1997-1998”, NM VRHS, Published September 2003, provides insight into the needs of the state. This study of linked data achieved an overall link rate of 93.4%; data findings were weighted to compensate for underestimation.

Risk Factors for Infant Mortality and Potential Strategies for Reducing Risks,
Based on Data from the 1997-99 Linked Birth Death Report of NM VRHS

Risk Factor	Rate Ratio Defined	Rate Ratio	Risk Reduction Potential
Gender of infant	Male:Female	1.2	None known; this ratio is attributed to genetics and the structure of the Y chromosome and other factors
Marital Status of Mother	Single:Married	1.4	Single mothers are more likely to have less family support for care of new infant; babysitters and partners often found to be a factor in infant deaths; Home visiting services and safe-affordable child care for single mothers who must return to work can reduce risks.
Educational attainment of mother	HiSchool or Less:More than High School	1.7	Lower educational rates are complex; some mothers are teens and haven't completed school, others have less educational attainment; home visiting is known to reduce this risk.
Age of mother	Less than 20:20-24	1.2	Teen mothers have less maturity and lower social support levels; programs for parenting teens in schools and home visiting can reduce this risk.
Place of residence, outside city limit	Rural: Urban	1.3	Issues of access to care are likely to be a factor for this disparity, including emergency care and ease of access to primary care to address infant illnesses or injuries.
Smoking during pregnancy	Smoke: No Smoke	1.5	Smoking cessation services and support in preconceptional, prenatal and post-partum periods are critical to reduce this risk. Home visiting can reduce this risk as well.
Prenatal Care	No Care: First Trimester	2.7	Women who get no prenatal care are more likely to be either teen or older; some are immigrants; a complex factor to address because of association with social determinants that keep some away from prenatal care.
Birth Weight	VLBW:LBW	16.8	Factors to reduce preterm/VLBW are not well established; more research is needed.
Birth Weight	LBW: Normal Birth Weight	70.5	Factors to reduce low birth weight do include smoking, alcohol and adequate nutrition, including breastfeeding support for mothers. Some mortality may be associated with difficulties parents face in caring for LBW infants.

Neonatal Mortality from the linked study and potential for reducing risk

LEADING CAUSES OF NEONATAL MORTALITY (NUMBER, RATE PER 100,000 LIVE BIRTHS) FROM LINKED STUDY	POTENTIALS FOR REDUCING RISK OF MORTALITY
Prematurity – low birth weight (90 deaths, Rate 110.4)	Preconceptional – prenatal prevention initiatives described above. Birth at a perinatal center that has high volume of high risk births; survival depends on birthweight -
Congenital Anomalies (78 deaths, Rate 96.4)	Preconceptional health, use of Folic Acid, no smoking, no drinking
Newborn Complications of Placenta, Cord & Membranes (24 deaths, Rate 30)	Placenta problems may be diagnosed by ultrasound; other complications often unanticipated;
Respiratory Distress of Newborn (15 deaths, Rate 18.7)	Delivery at perinatal center; care at a Neonatal Intensive Care Unit
Newborn affected by maternal complications of pregnancy (13 deaths, Rate 16.1)	Birth at a perinatal center that has high volume of high risk births

Post Neonatal Mortality from the Linked Study and NM PRAMS: An analysis of infant death that occurred between 29-365 days in conjunction with NM PRAMS data on preconception – prenatal health suggested some avenues for reducing the risks of death. An estimated 30% of new mothers had positive behaviors with respect to the factors of the Healthy Birth Index based on NM PRAMS data. While a study of attributable risk has not been done, nor has NM conducted a Perinatal Periods of Risk (PPOR) process, it is reasonable to examine leading causes of death with respect to the healthy birth factors. This chart is not inclusive of all potential risk-reduction strategies. This analysis proposes raising perinatal health to a state priority.

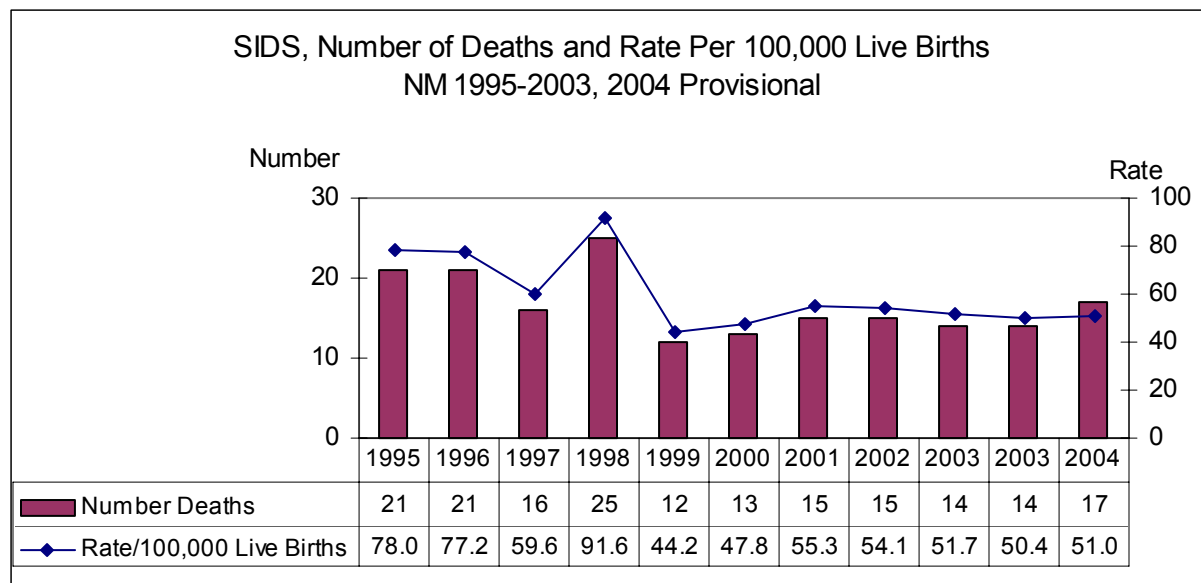
LEADING CAUSES OF POST-NEONATAL MORTALITY (NUMBER, RATE)	USED FOLIC ACID IN 3 MONTHS BEFORE PREGNANCY	NO SMOKING BEFORE, DURING, AFTER PREGNANCY	NO HEAVY OR BINGE USE OF ALCOHOL BEFORE OR DURING PREGNANCY	NO PHYSICAL ABUSE BY PARTNER BEFORE-DURING PREGNANCY	HAD EARLY & RECOMMENDED LEVELS OF PRENATAL CARE
SIDS (Number 56, Rate 69.1)		<i>Evidence based</i>			
Congenital Anomalies (Number 54, Rate 66.8)	<i>Evidence based</i>	<i>Evidence based</i>	<i>Evidence based</i>		<i>Evidence based</i>
Unintentional injury (Number 24, Rate 29.4)			<i>Evidence based</i>		
Prematurity – low birth weight (Number 13, Rate 15.8)		<i>Evidence based</i>	<i>Evidence based</i>	<i>Some evidence</i>	<i>Evidence based</i>
Assault - homicide (Number 9, Rate 11.7)			<i>Evidence based</i>	<i>Evidence based</i>	<i>Evidence based</i>

Leading causes in this period have potential for further reduction by combined public health and medical care initiatives::

- ❖ SIDS: while SIDS rates have fallen, continued focus is needed on discouraging smoking among new parents and safe infant sleep practices (sleep position and bedding). Home visiting can reduce this risk, <10% of new parents get a post partum home visit.
- ❖ Congenital anomalies: prevention of neural tube defects and cleft-lip and palate need continued focus on use of Folic Acid in 3 months before pregnancy; some evidence indicates a link between smoking and cleft-lip and palate. Preconceptional health initiatives are urgently needed.
- ❖ Unintentional injury: These deaths include motor vehicle crashes; other known injury risks include suffocation (improper bedding and sleep arrangements). Home visiting can reduce risk of injury deaths.
- ❖ Prematurity, low birth weight: Preconceptional health initiatives may reduce some of the risk. For those who have late or no prenatal care, the risk of infant mortality is 2.7+ times compared to those who had care. Home visiting for preterm and low birth weight reduces risks.
- ❖ Assault, homicide: Family violence is a NM priority; such homicides may be related to immature care-taking of infants. Home visiting can reduce risks.

Sudden Infant Death Syndrome (SIDS):

SIDS is the 3rd leading cause of all post-neonatal death for both NM and the US with comparable rates in 2002 (NM 54.1 and US 55.2). SIDS numbers and rates have decreased significantly from the 1980s, and continue to decrease from 1995-2003.



For infants who sleep prone (on stomach) the risk of SIDS is 3.5-9.3 times higher than for infants who sleep on their back. Maternal smoking with a 3.3-6.0-fold odds of SIDS is also a risk factor.

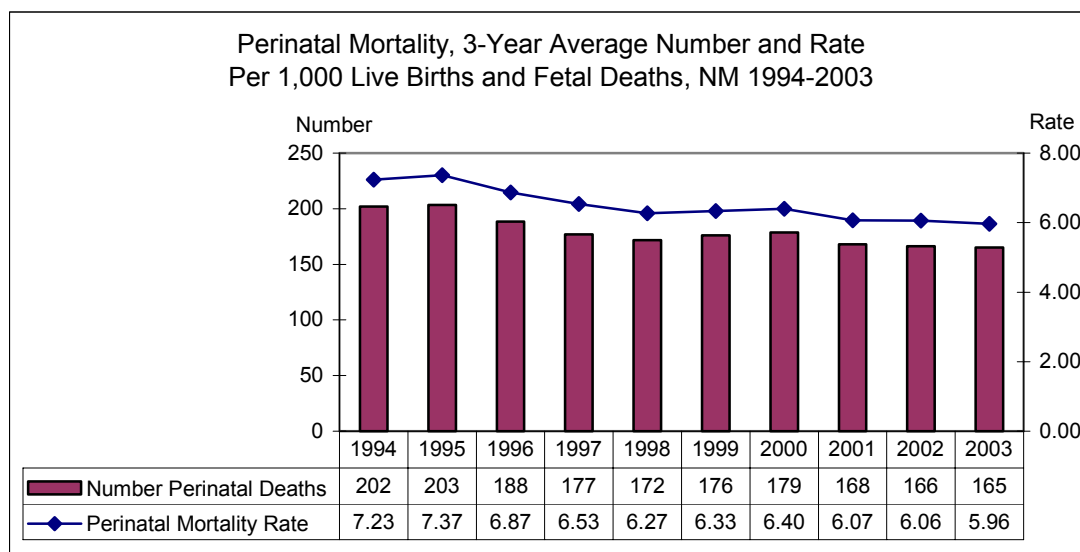
Intensive local and statewide programs are associated with the decline. According to NM PRAMS, the number of mothers who put their infants to sleep on their backs has increased from 45.3% in 1998 to 63.9% in 2002. An estimated 7% of mothers said their infant was regularly exposed to smoke, translated to an estimated 1,700 exposed per year. The NM CFR program found that educational targets need to include fathers, baby-sitters and infant day-care providers. Home visiting is an excellent avenue for SIDS prevention education but too few parents are reached.

PERINATAL MORTALITY:

The Healthy People 2010 goal is to reduce the death rate during the perinatal period to 4.5 per 1,000 live births + fetal deaths. The perinatal mortality rate comprises fetal deaths and early neonatal deaths <7 days as a ratio per 1,000 live births and fetal deaths. NM statute requires reporting of fetal deaths weighing 500 grams or more; prior to 1980 reporting was based on gestational age <20 weeks.

The NM perinatal death rate was 5.95 in 2003. Between 1994-2003 the 3-year average percent change in the perinatal mortality rate was -2.07%, a continuous decrease.

- ❖ The 3-year average percent decrease for early neonatal deaths <7 days was -1.87%
- ❖ The 3-year average percent decrease for fetal deaths was 1.5 times steeper than early neonatal deaths, -2.81%



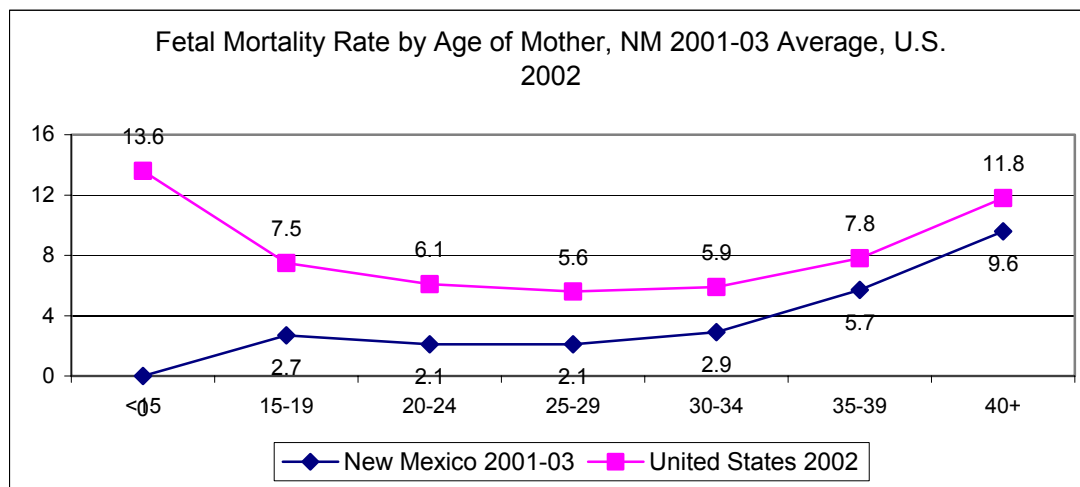
Data Source: New Mexico Vital Records and Health Statistics

The numbers of events are shown below for those not familiar with the magnitude in New Mexico.

	1992-1994-	1993-1995	1994-1996	1995-1997	1996-1998	1997-1999	1998-2000	1999-2001	2000-2002	2001-2003	2002-04 Provisional
3-Year Average Number of Early Neonatal Deaths <7 Days	95	96	89	79	80	80	79	76	77	79	78
3-Year Average Number of Fetal Deaths	107	107	99	98	91	96	100	92	89	81	85
3-Year Average Total Number Perinatal Deaths	202	203	188	177	172	176	179	168	166	160	163
3-Year Average Total Number Live Births and Perinatal Deaths	27,882	27,551	27,338	27,089	27,208	27,183	27,307	27,236	27,427	27,617	27,746

Data Source: New Mexico Vital Records and Health Statistics

The fetal death rate in NM has been lower than the national rate for many years, including age-specific rates. Comparisons with national rates are to be viewed with caution because of state-to-state differences in fetal death definitions and the unknown degree to which fetal deaths are under-reported. A multi-state collaborative study, to be released in fall 2005, may provide some guidance in assessing this data (personal communication W.Sappenfield, June 2005). Leading causes of fetal death in 2002 included 1) causes unspecified and unknown; 2) complications of the placenta, cord & membranes; and 3) congenital anomalies. Leading causes of early neonatal death included 1) disorders related to short gestation; 2) congenital anomalies; and 3) maternal complications of pregnancy. The NM fetal death rate by age of mother is seen below.



Source: Fetal Mortality by Age Mother, NM Residents 2001-03 and US 2002; US data source final 2002 data from CDC/NCHS, NVSR, Vol 52, No. 10; featured in Figure 3.12, Page 71, NM VRHS Annual Report of 2003

The leading causes of Infant Death, by Race-Ethnicity:

LEADING CAUSES –Infant Death Rate by Race Ethnicity

NEW MEXICO RESIDENTS 2001-2003 AVERAGE and United States 2001

UNITED STATES - ALL RACES

RATE/100,000 LIVE BIRTHS

	TOTAL	MALE	FEMALE
All Causes:	684.8	752.1	614.4
Congenital Malformations	136.9	143.5	130.0
Disorders related to Short Gestation & Low Birth Weight	109.5	117.9	100.8
Sudden Infant Death Syndrome (SIDS)	55.5	64.0	46.6
Newborn affected by Maternal complications of pregnancy	37.2	41.2	33.1

NEW MEXICO – ALL RACES

All Causes:	605.0	671.7	536.4
Congenital Malformations	157.4	169.7	144.7
Disorders related to short gestation and Low Birth Weight	136.5	147.9	124.7
Sudden Infant Death Syndrome (SIDS)	54.1	60.6	47.4
Newborn affected by maternal complications of Pregnancy	29.5	33.9	24.9
Newborn affected by complications Placenta, Cord and Membranes	22.1	29.1	15.0

WHITE-Non-Hispanic

All Causes:	519.8	536.2	502.6
Congenital Malformations	137.4	173.9	99.0
Disorders related to short gestation and Low Birth Weight	111.4	123.2	99.0
Sudden Infant Death Syndrome (SIDS)	81.7	72.5	91.4
Newborn affected by maternal complications of Pregnancy	22.3	7.2	38.1
Newborn affected by complications Placenta, Cord and Membranes	14.9	21.7	7.6

WHITE-Hispanic

All Causes:	610.1	738.2	481.3
Congenital Malformations	155.0	164.6	145.4
Disorders related to Short Gestation & Low Birth Weight	142.5	164.6	120.3
Newborn affected by maternal complications of Pregnancy	37.5	49.9	25.1
Sudden Infant Death Syndrome (SIDS)	25.0	39.9	10.0
Newborn affected by complications Placenta, Cord and Membranes	25.0	34.9	15.0

BLACK

All Causes:	1,227.3	1,285.6	1,160.3
Disorders related to Short Gestation & low Birth Weight	540.0	459.1	632.9
Sudden Infant Death Syndrome (SIDS)	196.4	275.5	105.5
Congenital Malformations	147.3	183.7	105.5
Newborn affected by complications Placenta, Cord and Membranes	147.3	91.8	211.0
Respiratory Distress of Newborn	49.1	91.8	0.0

AMERICAN INDIAN

All Causes:	681.5	678.9	684.3
Congenital Malformations	212.4	191.5	234.1
Disorders related to short gestation and Low Birth Weight	88.5	69.6	108.0
Sudden Infant Death Syndrome (SIDS)	70.8	69.6	72.0
Accidents (Unintentional Injuries)	35.4	17.4	54.0
Influenza & Pneumonia	35.4	34.8	36.0

ASIAN/PACIFIC ISLANDER

All Causes:	472.1	360.4	595.2
Disorders related to Short Gestation & Low Birth Weight	283.3	360.4	198.4
Congenital Malformations	188.9	0.0	396.8

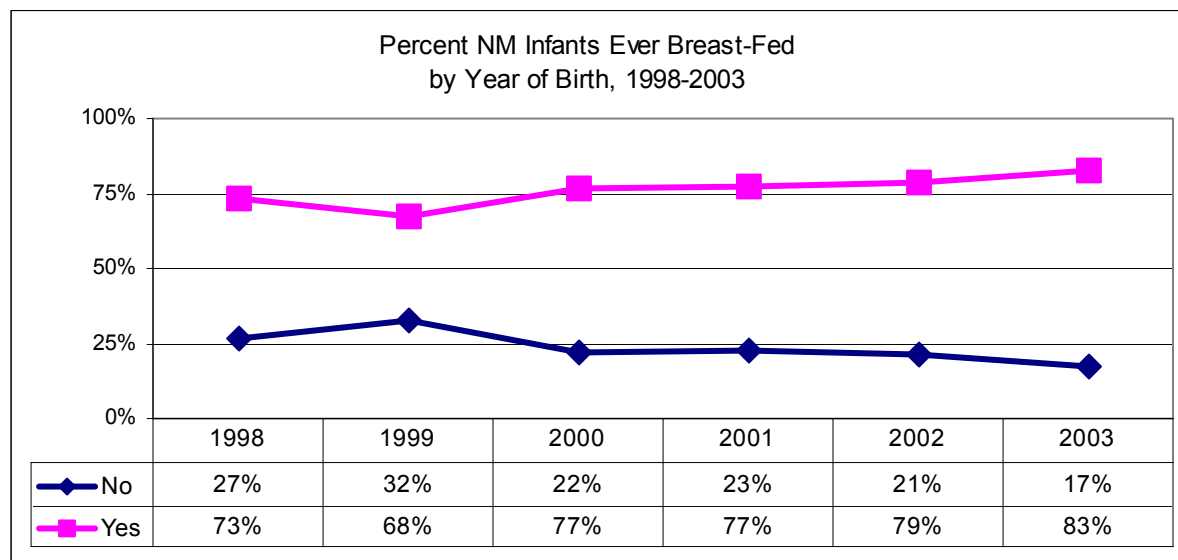
NOTE: U.S. mortality rates are per 100,000 live births and New Mexico infant death rates are per 100,000 population. NM rate numerators are infant deaths for the years 2001-2003, divided by 3; rate denominators are the 2002 population under 1 year.

US Data Source: CDC NCHS, National Vital Statistics Reports; Vol. 52, No. 9; Population from Bridged-race population of US Census in collaboration with NCHS, released January 2003.

INFANT FEEDING, FEATURING BREAST FEEDING

National Performance Measure 11: The percentage of mothers who breastfed their infant at hospital discharge

The American Academy of Pediatrics recommends exclusive breastfeeding for the first six months; the Healthy People 2010 Goals for breastfeeding are initiation 75% and continuation to 6 months 50%. Increased breastfeeding could cut annual health care costs in the US by \$3.6 billion. Breastfeeding affords health benefits to mothers and children as well as financial benefits to families, employers and payers of health care. It protects infants against respiratory and gastrointestinal illness, and may enhance cognitive development. For premature or low birth weight infants, breast feeding affords crucial nutrients and protection against serious illness or death in the neonatal period, and may be protective for SIDS. In the long term, it is associated with healthy weight in children. Benefits to mothers include reducing risk of postpartum blood loss, pre-menopausal breast cancer and ovarian cancer.






























Source: New Mexico PRAMS

In the time period 1998-2003, breastfeeding initiation increased steadily from 73% to 83% (NSCH); and NM PRAMS reported similar point estimates and trends 1998-2002.

Initiation of breastfeeding




























NM PRAMS, years 2001-2002. "Lower" and "Upper" refer to the error margin of the 95% confidence interval; a strikethrough indicates a large margin and the need to use the data with caution. Number of respondents=3161, population size=52072.

By maternal characteristic	Percent of mothers who initiated breastfeeding													
	0	10	20	30	40	50	60	70	80	90	100	%	Lower	Upper
All NM mothers												81.1	79.5	82.6
Age														
15-17												74.8	67.5	82.1
18-19												78.3	73.3	83.4
20-24												79.5	76.6	82.3
25-34												82.9	80.7	85.1
35 +												85.3	81.1	89.5
Ethnicity														
Non-Hispanic White												84.5	82.1	87.0
Native American												84.2	80.3	88.0
Hispanic White												77.6	75.3	79.9
Education														
Less than high school												74.7	71.4	78.0
High school												75.4	72.5	78.4
More than high school												90.8	89.2	92.5
Marital status														
Married												86.2	84.4	87.9
Not married												75.2	72.7	77.7
Any previous live birth														
No												84.7	82.4	87.0
Yes												79.0	77.0	81.0
Residence														
Central: District 1 urban												81.8	78.8	84.7
Northeast: District 2												86.3	83.6	89.0
Southwest: District 3												81.9	78.8	84.9
Southeast: District 4												70.5	67.0	74.1
Northwest: District 1 rural												84.1	80.9	87.3
Public assistance														
No												84.2	82.6	85.8
Yes												70.9	67.3	74.6
Payer of prenatal care														
IHS w/wo Medicaid/insurance												83.9	78.8	88.9
Medicaid w/wo insurance; no IHS												74.4	72.0	76.9
Insurance only												87.4	85.2	89.7
None												86.1	82.2	90.0

Between 1998-2003, the NSCH reported an average 20.4% of those who initiated had continued to 6 months. The National Immunization Survey reported that 39% ($\pm 5.6\%$) of NM children

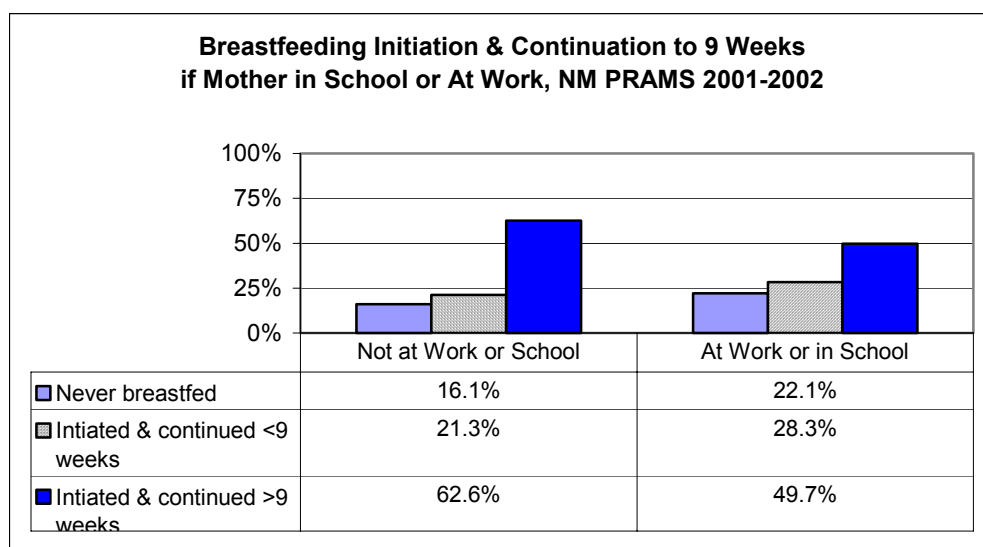
Continuation of breastfeeding

NM PRAMS, years 2001-2002. "Lower" and "Upper" refer to the error margin of the 95% confidence interval; a strikethrough indicates a large margin and the need to use the data with caution. Number of respondents who initiated breastfeeding=2546, population=40230.

By maternal characteristic	Among mothers who initiated breastfeeding, percent who continued at least 9 weeks						%	Lower	Upper
	0	10	20	30	40	50			
All NM mothers							69.6	67.6	71.5
Age									
15-17							50.4	41.4	59.4
18-19							65.1	58.4	71.7
20-24							62.8	59.1	66.5
25-34							76.3	73.6	79.1
35 +							75.6	70.1	81.1
Ethnicity									
Non-Hispanic White							73.8	70.7	76.9
Native American							71.0	65.8	76.2
Hispanic White							66.0	63.0	68.9
Education									
Less than high school							62.4	58.2	66.7
High school							62.9	59.3	66.6
More than high school							78.0	75.4	80.7
Marital status									
Married							75.3	72.9	77.6
Not married							62.1	58.9	65.3
Any previous live birth									
No							68.1	65.0	71.2
Yes							71.0	68.4	73.5
Residence									
Central: District 1 urban							72.8	69.1	76.5
Northeast: District 2							76.8	73.3	80.4
Southwest: District 3							68.0	63.9	72.1
Southeast: District 4							55.6	51.1	60.1
Northwest: District 1 rural							68.2	63.8	72.7
Public assistance									
No							71.7	69.6	73.8
Yes							61.5	57.0	66.1
Payer of delivery									
IHS w/wo Medicaid/insurance							73.4	65.9	80.8
Medicaid w/wo insurance; no IHS							63.3	60.4	66.2
Insurance only							76.4	73.5	79.4
None							73.7	67.0	80.3

were breastfed at 6 months. For infants born in 2001 or 2002, an estimated 26-28% were breastfed up to 6 months, a more accurate reflection of NM status given the increases in initiation. Promotion and support for breastfeeding is a high priority of the Title V MCH program and the NM and Tribal WIC programs. An estimated 80+% of New Mexico mothers initiated breastfeeding in 2003 according to the newly released National Survey of Child Health (NSCH); NM PRAMS reported an estimated 81% for years 2001-2002.

The NM PRAMS report for births in 2001-2002 affords a more detailed assessment of factors associated with breastfeeding initiation and continuation. Characteristics of mothers who achieved less than the statewide estimate for initiation of breastfeeding of 81.1% (95% CI 79.5, 82.6) or for continuation to at least 9 weeks of 69.6% (95% CI 67.6, 71.5) were similar and included: Only high school or less than high school education; Not married; On public assistance or on Medicaid; NM Public Health District IV (southwestern quadrant of the state); And, for continuation rate only, mothers age 20-24. Breastfeeding initiation and continuation in NM was associated with being in school or working, part-time or full-time.



Source: NM PRAMS

The NM Breastfeeding Taskforce has worked extensively to address factors that interfere with breastfeeding. The NM WIC Program increased its supply of breast-pumps and modified its policy so that mothers on WIC returning to work soon after 2 weeks receive support to continue breastfeeding.

In a survival analysis of PRAMS data, to be released in December 2005, Ssu Weng, MD, MPH (medical epidemiologist in the NM MCH Epidemiology Program) examined breastfeeding and WIC participation in NM. Provisional findings from this study found that among women with an annual income under \$23,000, women on WIC were less likely to be able to continue breast feeding to 6 months than those who were not on WIC (44% WIC, 54% non-WIC). Findings were adjusted for maternal age, education, ethnicity-race, smoking status, employment status, partner support and infant birth weight. Given that in 1988, breast feeding initiation among WIC mothers was ~46%, the progress made has been considerable (personal communication, J. Peacock). The recent study emphasizes the critical nature of the WIC program's efforts to support breastfeeding for infants.

INFANT HEALTH: EARLY INFANT CARE




























Newborn Hearing Screening, an estimated 92% of newborns received hearing screening before discharge from hospital, according to the program records.

Newborn Genetic Screening, an estimated 98% of newborns received genetic screening before discharge from hospital, according to program records.

Well Baby Visits: an estimated 77% of newborn infants began well baby visits to a doctor within the first 9 weeks after delivery in 2001-2002

Well-child visits

NM PRAMS, years 2001-2002. "Lower" and "Upper" refer to the error margin of the 95% confidence interval; a strikethrough indicates a large margin and the need to use the data with caution. Data available for only 2812 of 3161 respondents, population=46093 of 52072.

By maternal characteristic		Percent of mothers whose infant had an appropriate number of well-child visits													
		0	10	20	30	40	50	60	70	80	90	100	%	Lower	Upper
All NM mothers													77.4	75.8	79.0
Age															
15-17													76.7	69.8	83.6
18-19													76.3	70.8	81.7
20-24													74.6	71.5	77.6
25-34													78.9	76.5	81.3
35 +													81.0	76.3	85.6
Ethnicity															
Non-Hispanic White													80.3	77.6	82.9
Native American													63.1	58.0	68.3
Hispanic White													78.3	76.0	80.6
Education															
Less than high school													70.9	67.4	74.5
High school													76.4	73.6	79.3
More than high school													82.5	80.2	84.8
Marital status															
Married													81.0	79.0	83.0
Not married													73.1	70.5	75.7
Any previous live birth															
No													80.7	78.2	83.2
Yes													75.0	72.8	77.1
Residence															
Central: District 1 urban													80.4	77.3	83.4
Northeast: District 2													83.5	80.7	86.4
Southwest: District 3													75.9	72.4	79.4
Southeast: District 4													81.1	78.1	84.2
Northwest: District 1 rural													61.9	57.6	66.3
Public assistance															
No													79.9	78.2	81.7
Yes													69.3	65.6	73.0
Payer of delivery															
IHS w/o Medicaid/insurance													54.7	46.7	62.8
Medicaid w/o insurance; no IHS													74.1	71.8	76.5
Insurance only													86.1	83.8	88.5
None													74.2	67.9	80.4

THE HEALTH AND WELL BEING OF MOTHERS, INFANTS AND FAMILIES: HOME VISITING

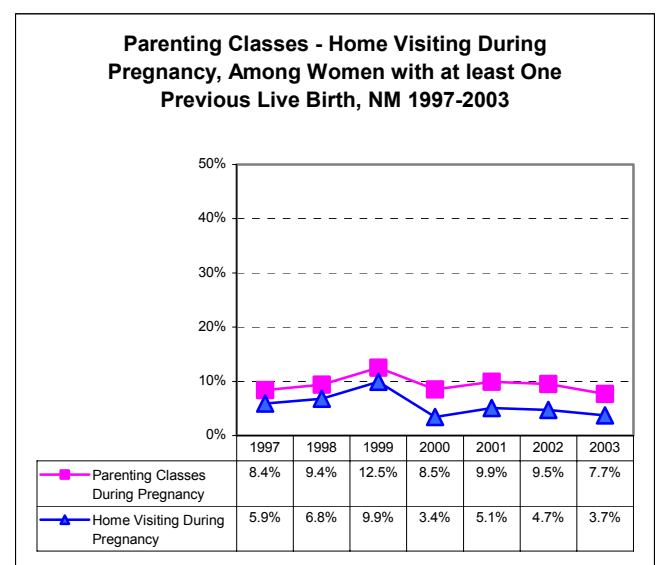
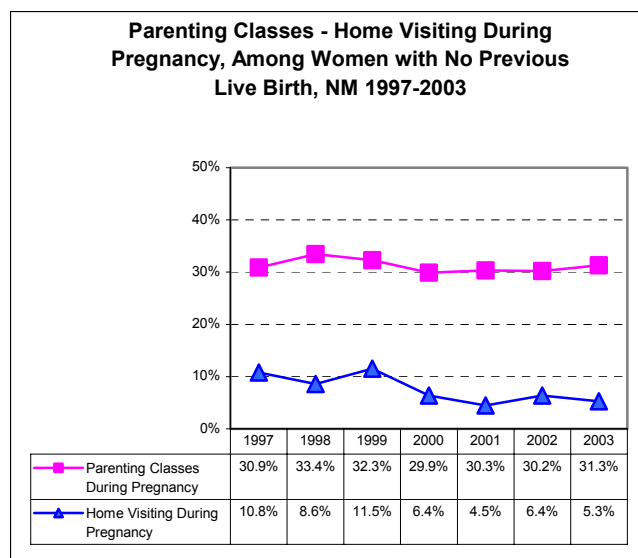
State Performance Measure 2: the percent of first time mothers and infants that receive support services for parenting through community home visiting and related support programs

In today's world there are increasing challenges of parenting and providing stable family life as demonstrated by the following changes in family structure: an increase in teen and single parents and those not prepared to parent their children; increased divorce rate; children spending less time with their parents due to parent's need to work; increased number of children in foster care as result of unwanted pregnancy or substantiated child abuse-neglect. The high proportion of young families who live with the burden of poverty creates even more burden (from state detail performance measure description).

There are no Healthy People Goals regarding home visiting for expectant parents or parent(s) of children age 0-3 years. Related objectives concern the need to increase the percentage of persons who receive appropriate health counseling about health behaviors. A developmental goal (16.7) is to increase the percent of new parents who attend parenting classes.

The NM state objective as developed in 2000 was to reach 14% of first time mothers; it was reset to 26% for 2004. The state objective did not specify if the home visiting-parenting class goal pertained to the prenatal or post-partum period.

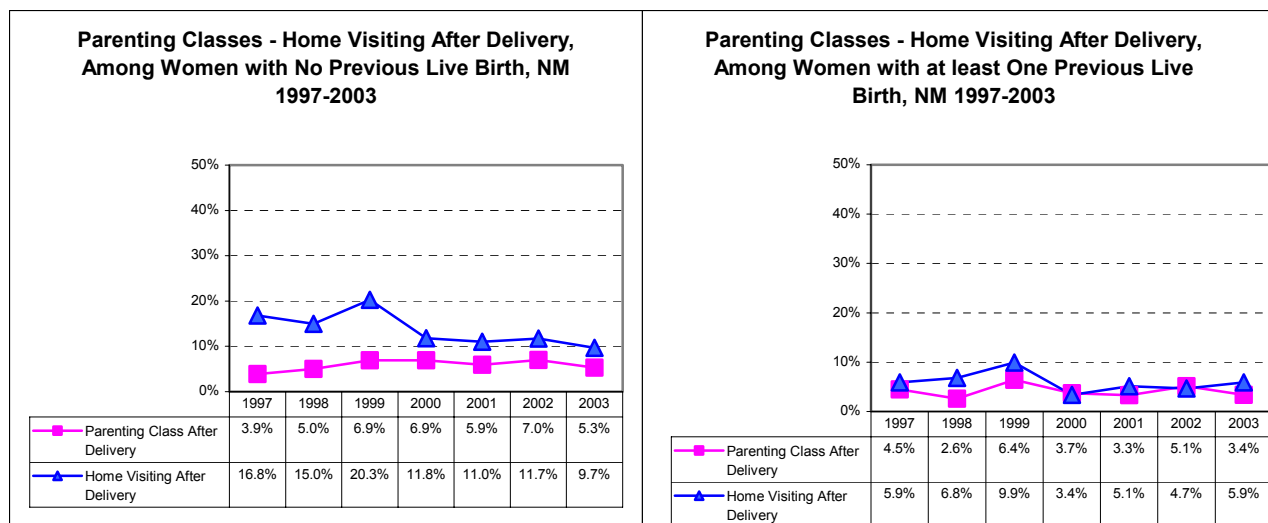
The next pairs of graphs depict parenting classes and home visiting performance for NM, by prenatal period and by women with no previous birth or women with at least one previous birth:



In the prenatal period, NM continued far below the target of 14%. Mothers with at least one previous birth were 3 times less likely to get these services.

In the post-partum period, the target for first time mothers was reached in period 1997-1999; and since then there was a steep decline in home visiting, dropping to an all time low of 9.7.

Parenting classes have remained somewhat steady, reaching about 5% of the target population in 2003.



Home visiting is an evidenced based public health intervention that can have a significant impact in the short term and the longer term. There is a large body of evaluation literature that describes the characteristics of programs that have an impact; they are comprehensive with a frequency of visiting tied to developmental needs of pregnant women and children 0-3 years of age. Short-term impact includes improved birth outcomes, improved immunization rates, lower child abuse or neglect, lower unintentional injuries, lower SIDS deaths, and related outcomes.

The data for NM on home visiting tell only if the new mother had at least one home visit or participated in at least one parenting class in the prenatal period and in the post partum period up to about 9 weeks.

- ❖ As seen in graphs above, the proportion of women who reported having had parenting classes or home visiting services and who had a live birth in period 1997-2003 was very different among women who had at least one previous birth and first time mothers. First time mothers

were three times more likely to get parenting classes; and were a little more likely to get home visiting.

❖ In both groups, the proportion that received a home visit between 1997-1999 was higher than the years 2000-2003. The reason for this drop needs to be explored by program staff, with respect to the availability of home visiting services - an inquiry that can be scheduled in the 2005-06 grant period if resources allow.

❖ The bottom set of graphs shows that after delivery, home visiting services were used more than parenting classes after delivery in both groups. Use of home visiting in this critical period dropped off in years 2000-2003 as well.

For the period 2001-2002 (most current PRAMS data for this level of analysis), there were selected groups who got more home visiting during pregnancy (statewide estimate of 5.1% , 95%CI 4.3, 5.9) and after delivery (statewide estimate of 8.5%, 95%CI 7.5, 9.5). This analysis indicates that home visiting services are reaching a greater proportion of groups who characteristically are at greater risk and need home visiting:

Selected Groups	Prenatal Home Visiting*	Post Partum Home Visiting*
Statewide Estimate	5.1% (4.3, 5.9)	8.5% (7.5, 9.5)
Teens age 15-17	11.5% (6.3, 16.6)	17.5% (11.4, 23.5)
Native Americans	10.2% (7.3, 13.2)	13.2% (9.9, 16.5)
Northwest Public Health Division Counties	8.8% (6.3, 11.3)	11.6% (7.3, 15.9)
Prenatal Care by I.H.S.	11.6% (7.3, 15.9)	14.6% (9.3, 20)

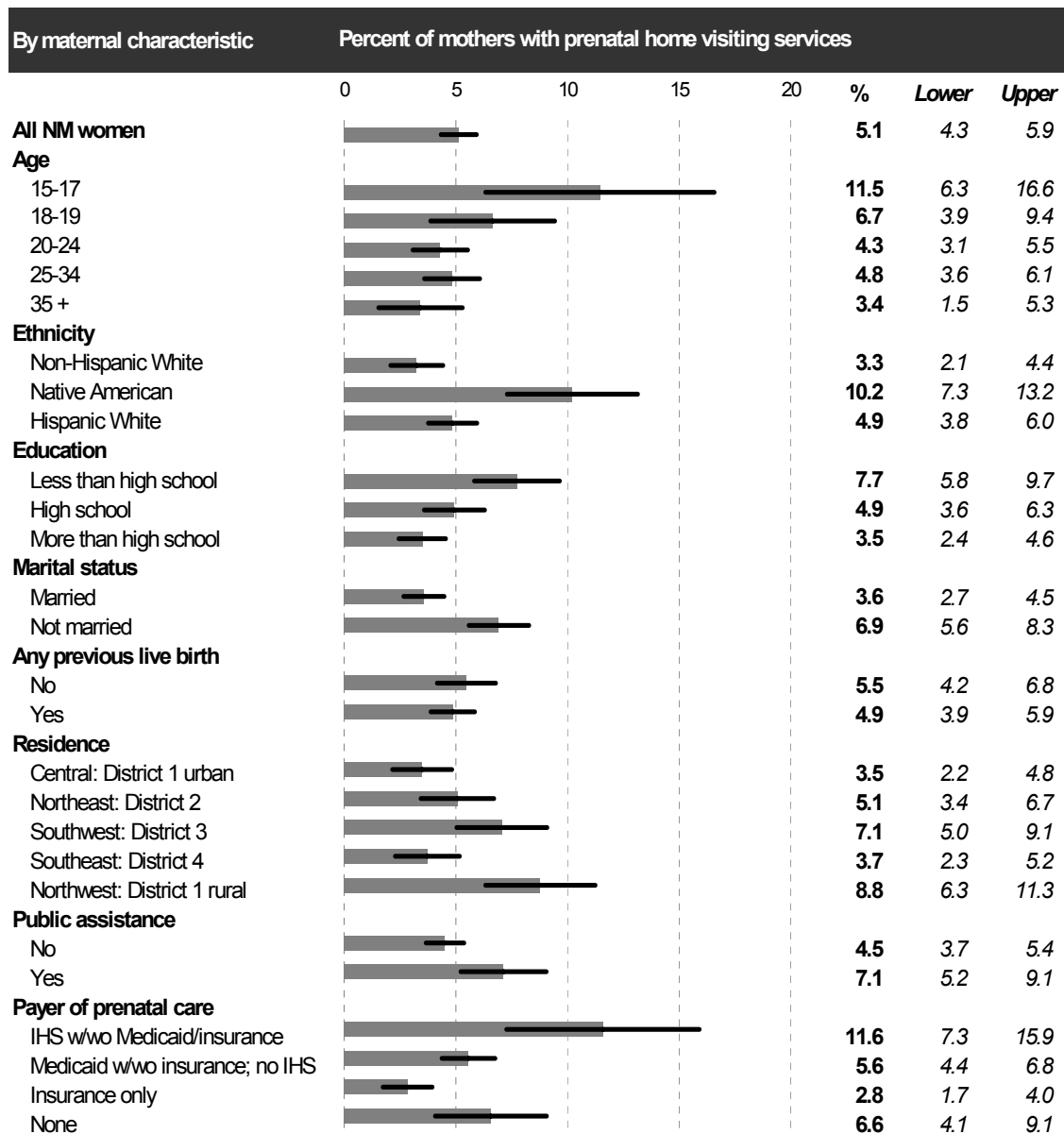
*Estimated Percent shown with 95% Confidence Interval in Parentheses)

Home visiting services vary according to the training of visitors and when visits are made (prenatal or postpartum), duration, and frequency. Visitors include nurses, midwives, and community health workers from private offices or organizations, and public agencies. Because of early hospital discharges, these services are especially important. Home visit follow-up after 24-hour discharge can save about \$500 in *net* costs per infant (study in 1996).ⁱ Home visiting programs, generally comprehensive in scope, can improve the home environment, or parentingⁱⁱ or breastfeeding practices.ⁱⁱⁱ Some evaluations showed benefits such as deferral of subsequent pregnancies,^{iv} increased maternal employment, prevention of child abuse;^v or decreased duration of welfare use.^{vi} For low-income families, the cost of home visiting was recovered by less overall government spending of \$180 per family (study in 1993.^{vii} NM has few comprehensive programs. In

NM border areas, *promotoras* visit pregnant and recently delivered mothers. Other known programs include a limited number of visits for mothers served by Families FIRST, the Early Head Start Program and selected initiatives of the former County MCH Councils.

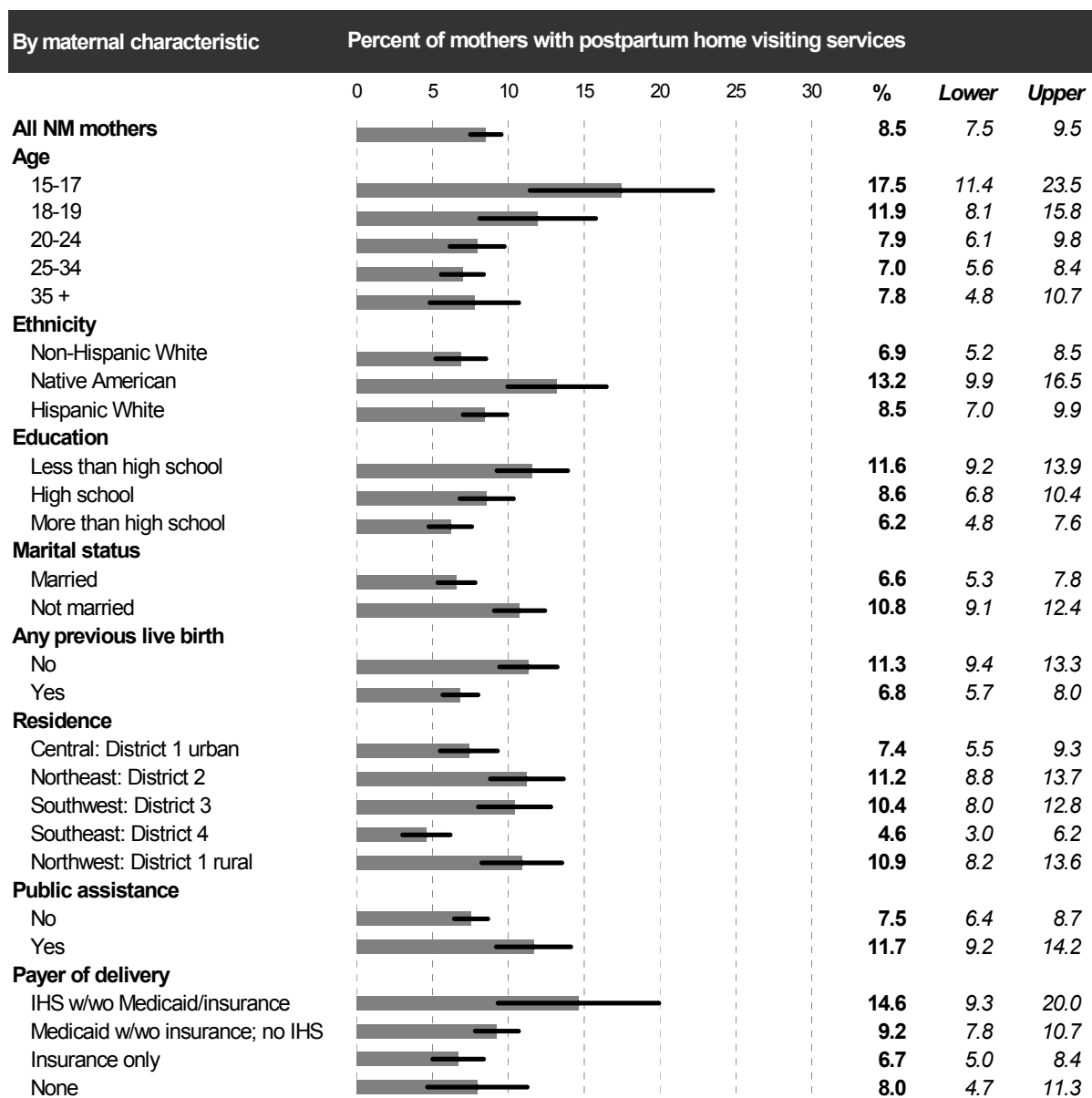
Home visiting services: prenatal

NM PRAMS, years 2001-2002. "Lower" and "Upper" refer to the error margin of the 95% confidence interval; a strikethrough indicates a large margin and the need to use the data with caution. Number of respondents=3161, population=52072.



Home visiting services: postpartum

NM PRAMS, years 2001-2002. "Lower" and "Upper" refer to the error margin of the 95% confidence interval; a strikethrough indicates a large margin and the need to use the data with caution. Number of respondents=3161, population=52072.



HEALTH OF NEW MEXICO CHILDREN

The newly released National Survey of Children's Health is cause for much celebration because it is the first state level, population-based surveillance of the health of NM children and their parents. This section of the NM needs assessment will feature more detail on some of the indicators found in this profile; the state has only begun to analyze and use this new data.

An estimated 81.9% of NM parents reported their children to be in excellent or very good health; nearly 8% had moderate or severe health problems. An estimated 36.6% of parents had one or more concerns about their child's learning, development or behavior.

National Survey of Children's Health, 2003: New Mexico Profile

Children ages 0-17

National % **State %**

Child's Health Status			
Overall Child Health Status	% children whose overall health is excellent or very good	84.1	81.9
Moderate or Severe Health Problems	% children with health problems rated as moderate or severe by parents	7.9	8
Impact of Asthma on the Family	% children with asthma whose families are greatly or moderately affected in some way by child's health condition	16.3	13.2
Impact of Asthma	% children affected by asthma during past year	8	8.1
Injury	% children ages 0-5 with injuries requiring medical attention during past year	9.4	8.1
Missed School Days	% school age children who missed 11 or more days of school in the past year due to illness or injury	5.2	6.8
Parents' Concerns	% children ages 0-5 whose parents have one or more concerns about child's learning, development, or behavior	36.6	36.2
Socio-Emotional Difficulties	% children ages 3-17 with moderate or severe difficulties in the area of emotions, concentration, behavior, or getting along with others	9.2	8.6
Breastfeeding	% children ages 0-5 who were breastfed for any length of time	72.3	76.5
Child's Health Care			
Current Health Insurance	% children currently insured	91.2	90.4
Consistency of Insurance Coverage	% children currently uninsured or not insured for some period during the past year	14.9	16.9
Preventive Health Care	% children with a preventive medical care visit in the past year	77.8	72.7
Preventive Health and Dental Care	% children with both a preventive medical care visit and a preventive dental care visit in the past year	58.8	55.3
Mental Health Care	% children with current emotional, developmental, or behavioral problems who received some type of mental health care during the past year	58.7	58.3
Medical Home	% children who have a personal doctor or nurse from whom they receive family-centered, accessible, comprehensive, culturally sensitive and coordinated health care	46.1	39

Source: Child and Adolescent Health Measurement Initiative (2005). National Survey of Children's Health. Data Resource Center on Child and Adolescent Health. Website www.nschoadata.org, download June 2005

An estimated 58.7% of children with current emotional, developmental or behavioral problems received some type of mental health care during the year. Additional analysis

of the socio-emotional difficulties of young children will be critical to the planning work of the NM Children's Cabinet, those planning strategies to address mental health services for school age children and youth, and the Title V MCH Program in 2006. Strategically, the suicide prevention program is researching approaches to reduce the stigma associated with seeking and receiving mental health care.

This next section provides selected information about activities, family life and the neighborhood. The safety of the neighborhood from the NSCH was analyzed further in the section on children's safety.

National Survey of Children's Health, 2003: New Mexico Profile

Children ages 0-17

National % **State %**

Child's School and Activities			
Early Childhood School	% children ages 3-5 who regularly attended preschool, kindergarten, Head Start or Early Start during the past month	60.7	56.3
Activities Outside of School	% children ages 6-17 who participate in one or more organized activities outside of school	81	76.8
Repetition of Grade	% children ages 6-17 who repeated at least one grade in school	11.3	10.5
Staying Home Alone	% children ages 6-11 who stayed home alone during the past week	15.9	14
Child's Family			
Reading to Young Children	% children ages 0-5 read aloud to by family members every day during the past week	47.8	42.9
Household Smoking	% children who live in households where someone smokes	29.5	27.3
Religious Services	% children who attend religious services at least once a week	55.7	55.5
Mother's Health	% children with mothers whose overall physical and mental health is excellent or very good	58.9	53.3
Child and Family's Neighborhood			
Supportive Neighborhood	% children living in neighborhoods parents describe as supportive	81.4	78
Safety of Child in Neighborhood	% children living in neighborhoods or communities parents feel are usually or always safe	83.8	81.2
Child Care Issues	% children ages 0-5 whose parents had to make different child care arrangements in the past month or a job change for child care reasons in the past year, or both	33.2	36.7
Source: Child and Adolescent Health Measurement Initiative (2005). National Survey of Children's Health. Data Resource Center on Child and Adolescent Health. Website www.nschdata.org , download June 2005			

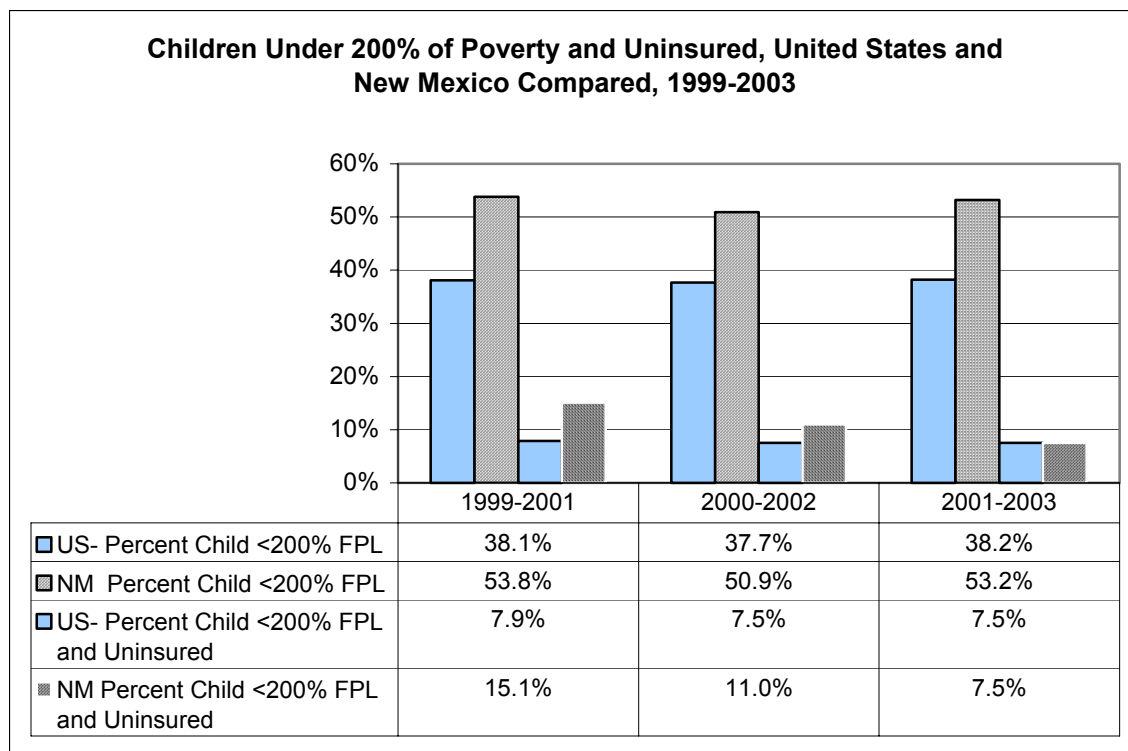
An estimated 60.7% of children age 3-5 attended some form of early childhood school; a proportion a little higher than the nation at 56.3%. While child care is a critical topic for the Early Childhood Comprehensive Systems project in NM, there was not sufficient time before this needs assessment closed, to do further analysis.

HEALTH OF CHILDREN IN NEW MEXICO: CHILD HEALTH INSURANCE

National Performance Measure 13: The percent of children without health insurance

The Healthy People 2010 Goal is to increase the proportion of persons with health insurance to 100%.

Access to primary care, preventive care, and tertiary care often depends on whether a person has health insurance. Uninsured people are less than half as likely as those with insurance to have a primary care provider; to have received appropriate preventive care, such as recent mammograms or Pap tests; or to have had any recent medical visits (CDC MMWR 44 in 1995). Evidence suggests that lack of insurance over an extended period significantly increases the risk of premature death and that death rates among hospitalized patients without health insurance are significantly higher than among patients with insurance. The National Health Interview Survey indicated that Medicaid expansions that increase the proportion of a State's population eligible for Medicaid lead to increases in enrollment, enhanced utilization of medical services, and lower child death rates (Reinhardt, NEJM 330:1994).

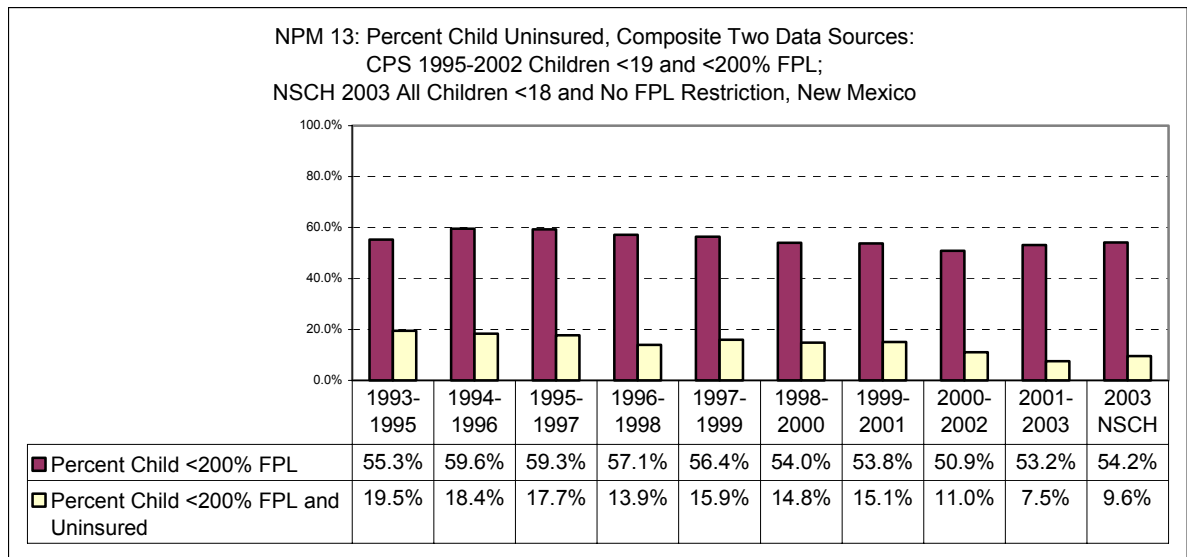


Source: Current Population Survey, US Census, www.census.gov.

NM ranked among the worst five states for the highest proportion of children living at or below the federal poverty level (FPL) for many years. Thus it is no surprise to see that there are 1.4 times as many NM children at or below 200% of poverty than in the nation. What is interesting is that the proportion of uninsured children in the nation was 7.5% and did not change for period 1999-2003. On the other hand, while poverty levels remained high in NM, the proportion of uninsured children decreased about 50% from 15.1% in period 1999-2001 to 7.5% in 2001-2003. In real numbers, in the five year period of time, an estimated 27,000 fewer children were uninsured (81,000 in 1999-2001 period to 54,000 in the 2001-2003 period).

The Medicaid reports of June 2001-2004 indicated an average annual percent increase in children enrolled of 6.6%. In June 2001 there were 223,290 children enrolled; in June 2003 the number was 260,500; an increase of 37,000 children. (Monthly Statistical Reports, NM HSD).

In 2003, the National Survey of Children's Health (NSCH) that found 9.6% or 48,134 New Mexico children age 0-17 had no insurance as compared to 8.8% of US children. While the proportion of low-income and very poor children <200% of poverty in New Mexico has not changed in over 10 years, it does appear that fewer of these children are uninsured – and hence, have access to health care.



Sources: Current Population Survey, US Census www.census.gov/cps and weighted analysis of the NSCH data for NM

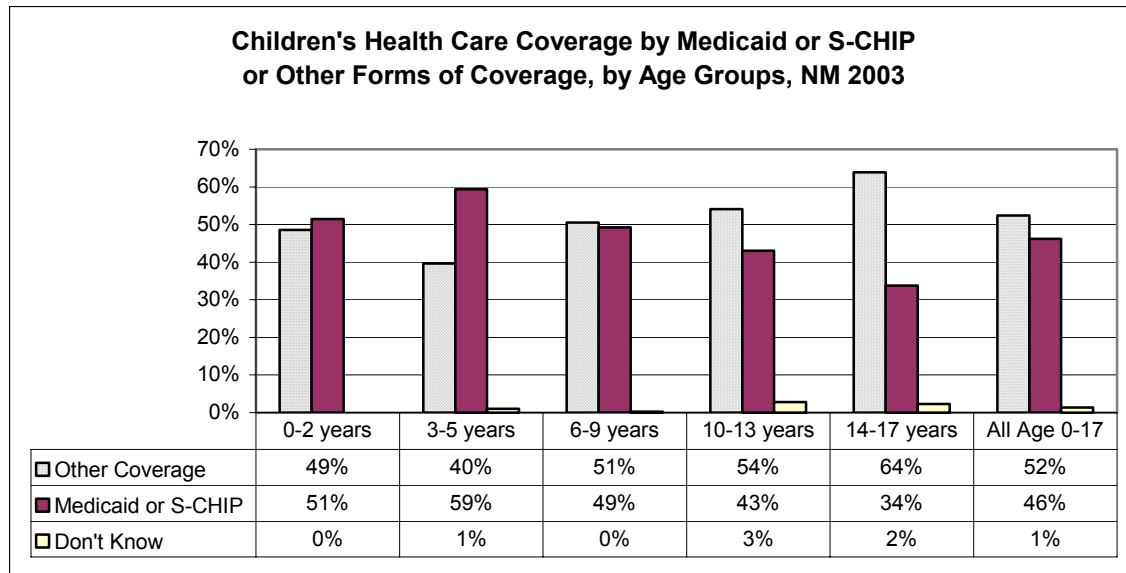
The NSCH reported key differences in having any form of health insurance. While the NSCH does not provide more localized data – such as by county or public health district – it does describe disparities in coverage by age group.

Percent of Children with Any Form of Health Insurance, by Age Groups, NM 2003			
Age Child	No	Yes	Don't Know
0-2 years	10.8%	89.2%	0.0%
3-5 years	6.1%	93.9%	0.0%
6-9 years	9.8%	90.2%	0.0%
10-13 years	11.1%	88.4%	0.5%
14-17 years	9.5%	90.5%	0.0%
All children 0-17 years	9.6%	90.3%	0.1%

Data Source: Centers for Disease Control & Prevention, National Center for Health Statistics, State & Local Area Integrated Telephone Survey, National Survey of Children's Health, 2003. Analysis by NM MCH Epidemiology

- There were disparities in coverage by race and ethnicity, uninsured included
- ❖ 7% or 11,300 White children
 - ❖ 10.2% or 25,330 Hispanic children, a rate that was 1.4 times White children
 - ❖ 12.2% or 983 Black children
 - ❖ 14.5% or 9,000 Other children - in the New Mexico sample of the NSCH this group included Native Americans. The rate was 2.1 times that for White Children. It would seem that Native American respondents in this group – all of whom are eligible for Indian Health Services – did not consider I.H.S. to be a form of coverage in this survey.

Nearly half of NM children were covered by Medicaid or the state Child Health Insurance Program (S-CHIP). An estimated 46.9% of all children were covered by Medicaid or the state child health insurance program (S-CHIP); and 52.4% had some other forms of coverage (health insurance, pre-paid plans such as HMOs).



Data Source: Centers for Disease Control & Prevention, National Center for Health Statistics, State & Local Area Integrated Telephone Survey, National Survey of Children's Health, 2003. Analysis by NM MCH Epidemiology

An estimated 16.9% of NM children age 0-17 were currently uninsured or not covered for some period of time in past year compared to the US figure of 14.9%.

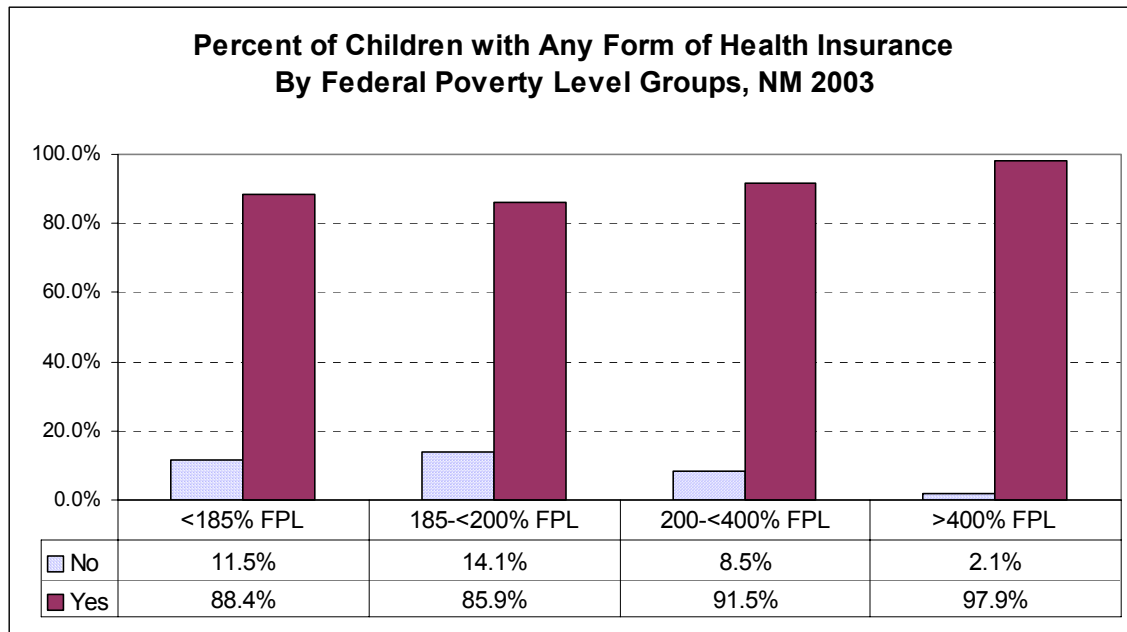
Of NM children who had current coverage, 7.96% reported gaps in coverage. An additional 9.6% had no coverage at all. This figure approximates the national report of NM data (16.9%).

Those whose coverage was Medicaid had 2.24 times the risk of not being covered at some time in the past year compared to those with other forms of coverage (RR 2.24,). This data was collected in 2003, before Medicaid instituted rules that required re-certification for eligibility every six months in (xx date). It is thought that the risk of gaps increased during 2004-05.

Disparities in insurance in NM for 2003 were reported in the NSCH 2003; more analysis is needed to understand these data and their implications for policy or program initiatives:

Children of parents not born in the US, and children not born in the US were more likely to not have current health insurance in 2003. See section on immigrant health.

Between 11-14% of NM children age 0-17 were potentially eligible for Medicaid (<185% FPL) or SCHIP (185-235% FPL) and were not covered by any form of health insurance.



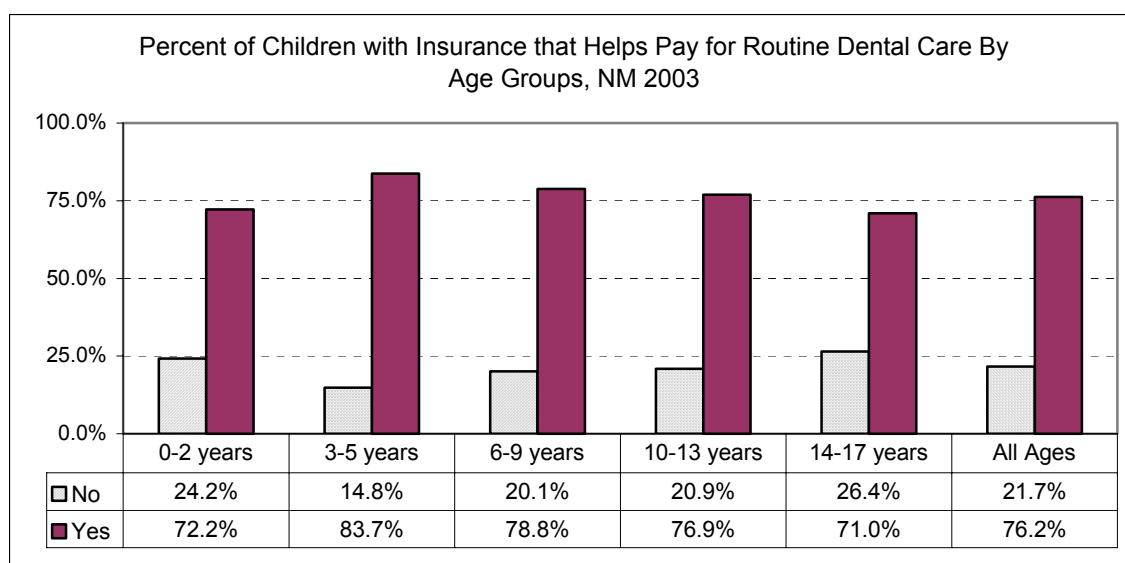
Data Source: Centers for Disease Control & Prevention, National Center for Health Statistics, State & Local Area Integrated Telephone Survey, National Survey of Children's Health, 2003. Analysis by NM MCH Epidemiology

In summation, it appears that child health insurance coverage has improved and may still be improving as this report goes to press. Some of the key issues regarding health insurance coverage are known to persist (abstracted from Who's Uninsured in New Mexico and Why? www.familiesusa.org and from qualitative information gleaned during the needs assessment exercise):

- ❖ Employer-based coverage for those who work in small businesses continues to be unaffordable for the business or the employee. About 23% of New Mexicans worked for small employers in 2000.
- ❖ Service and labor jobs are less likely to provide insurance; about 63% of uninsured workers hold such jobs, although they make up only 40% of the workforce.
- ❖ Part-time workers are often not eligible, thus their children are affected.
- ❖ Low wage workers are often not able to afford health insurance offered by the employer.
- ❖ People who lose their jobs often lose health insurance; the unemployment rate in NM went from 4.8% in 1999 to over 6% in April 2005.
- ❖ People –including children- with any pre-existing condition have to pay significantly more for private insurance or may not be able to afford it at all.
- ❖ Keeping current is a challenge – families who lose work or have decline in income may not be aware they qualify for Medicaid or S-CHIP.

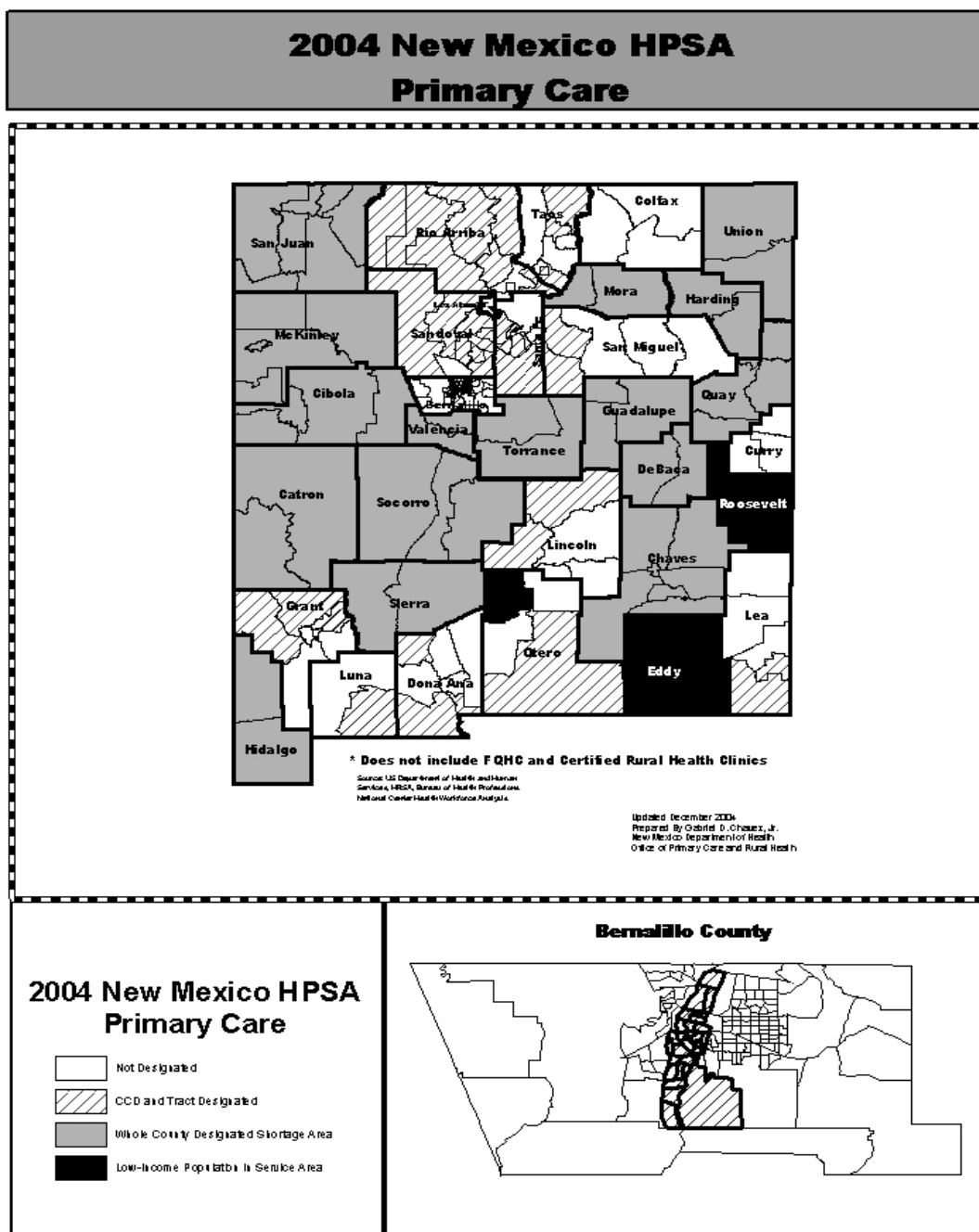
- ❖ The present 2005 policy to require re-certification every 6 months may begin to show up in the data as a gap in coverage, or no coverage for those who may be discouraged by the paperwork involved.
- ❖ Immigration status imposes a 5-year delay from time of legal entry to the US for children to apply for Medicaid or S-CHIP. Citizen children living in immigrant families are eligible for Medicaid/SCHIP but may not enroll because of parents' language barriers, confusion about eligibility and program rules and fear of repercussions for using public benefits (cited in Future of Children 2003 as well as direct observation by NM public health staff)
- ❖ Language barriers cause confusion about eligibility and program rules and in the case of immigrants fear of repercussions for using public benefits
- ❖ The increasing cost of medical care and hospitalization is a risk because it discourages providers from accepting Medicaid children and families.

The proportion of children who had some coverage for dental care is less than the proportion who had some form of health insurance, it is the first time such data has been available so there are no trends. While over 70% of children had coverage, there are real gaps in access. There are still too few dentists who accept Medicaid, and children in smaller communities may have to travel over 100 miles to reach a dentist.

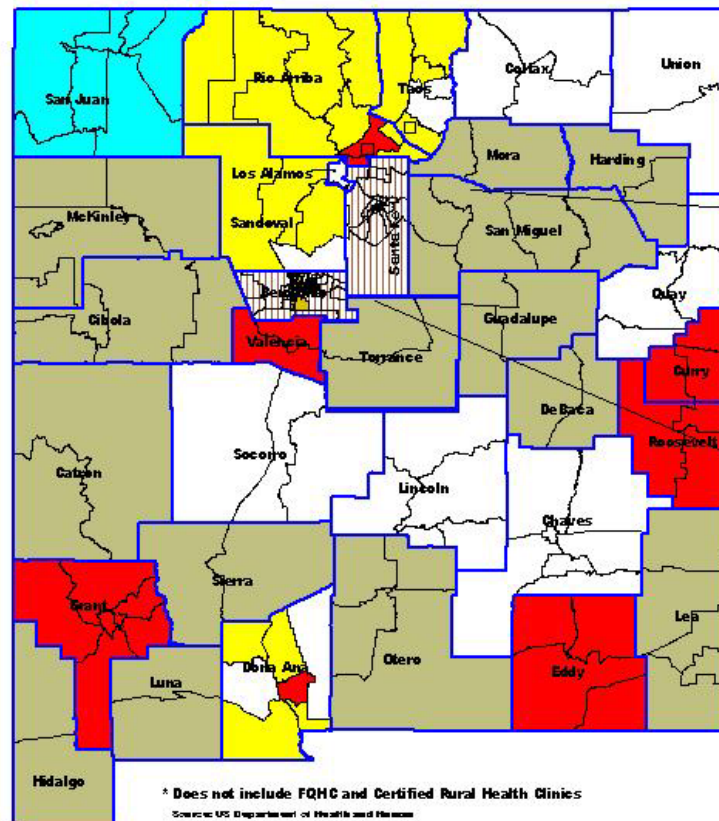


Data Source: Centers for Disease Control & Prevention, National Center for Health Statistics, State & Local Area Integrated Telephone Survey, National Survey of Children's Health, 2003. Analysis by NM MCH Epidemiology

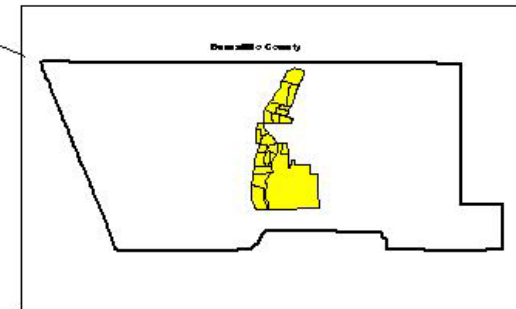
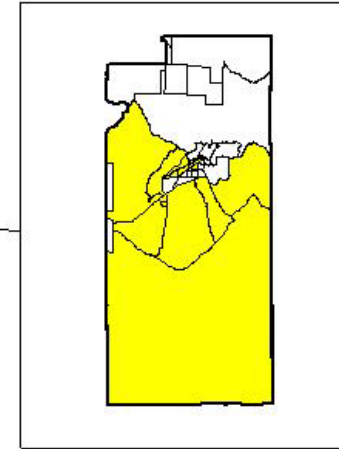
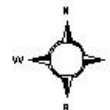
ACCESS TO PRIMARY CARE, DENTAL CARE AND MENTAL HEALTH SERVICES IN 2004: Large areas of New Mexico have health professional shortages that impact the population's access to care. These maps are included to aid the reader in identifying areas that are described as having poor access for the population.



2004 HPSA Dental



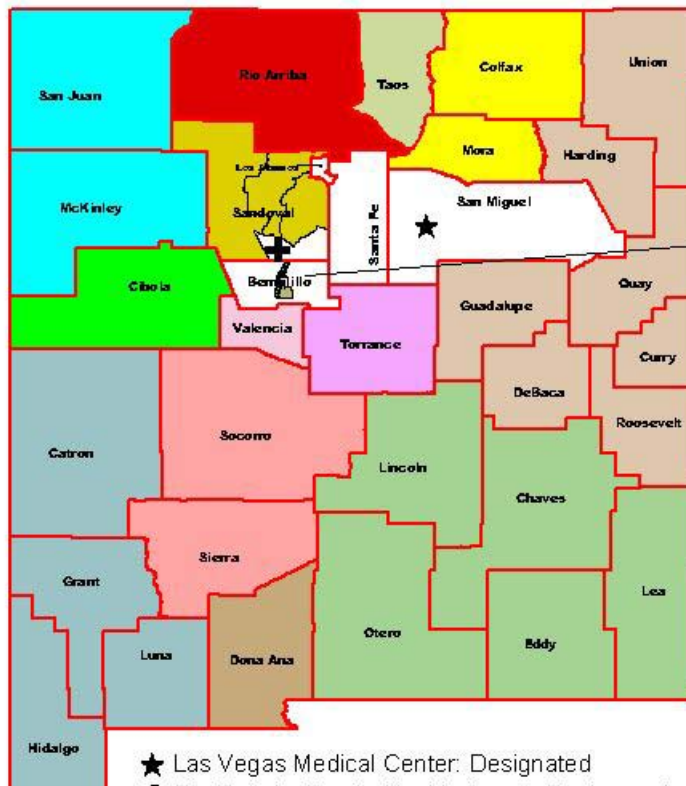
* Does not include FQHC and Certified Rural Health Clinics
 Source: US Department of Health and Human Services, HHS, Bureau of Health Workforce
 National Center Health Workforce Analysis



- County Boundaries
- NM HPSA's Dental
- Not Designated
- CCD and Tract Designated
- Whole County Designated
- Indian Population Designated in Service Area
- Low-Income Population in Service Area
- County Part Designated

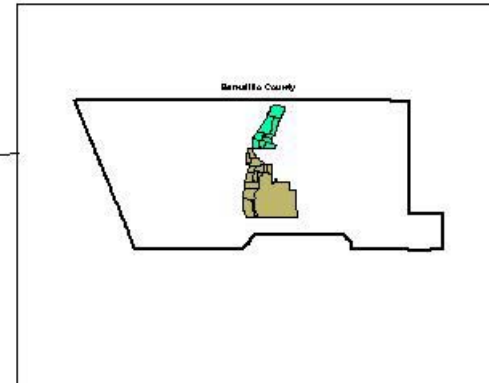
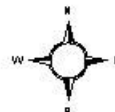
XXXXX

2004 HPSA Mental Health



★ Las Vegas Medical Center: Designated
 + Rio Rancho Family Health Center: Designated

* Does not include PHHC and Certified Rural Health Clinics
 Sources: US Department of Health and Human Services, HRSA, Bureau of Health Professions
 National Career Health Workforce Analysis



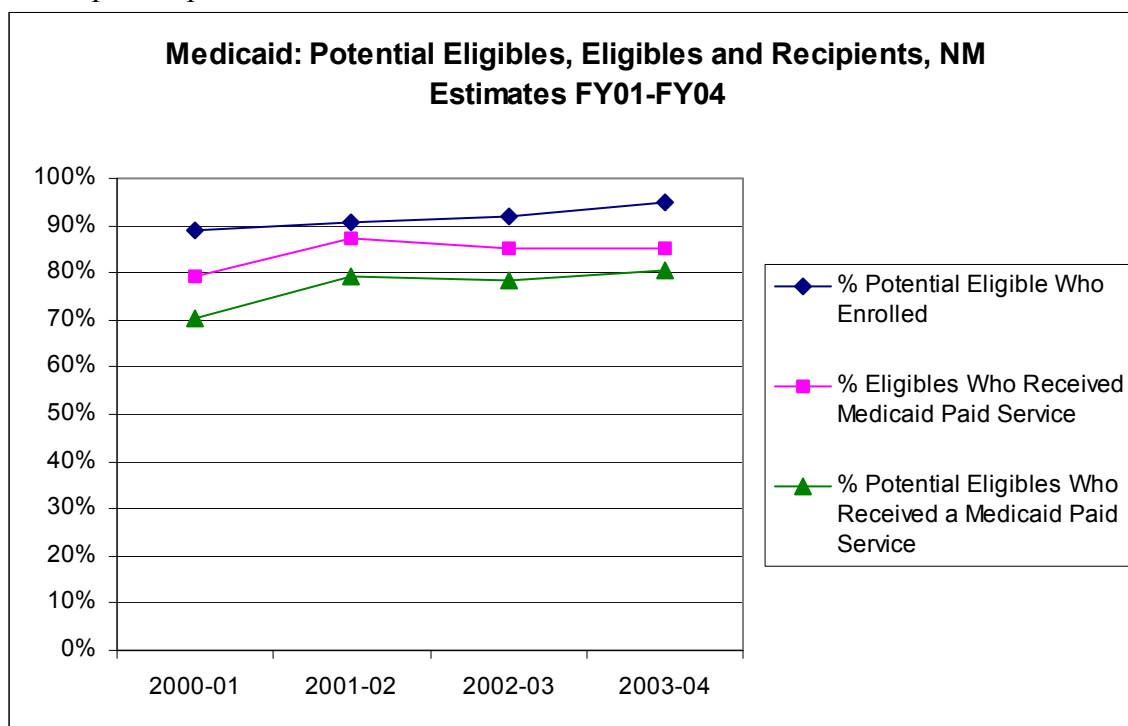
- Bernalillo County Mental Health HPSA's
- North Valley Mental Health Service Area
 - Southwest Valley Mental Health Service Area
 - North Sandoval County Mental Health Service Area
 - Cuba, Jemez, and Santo Domingo CCD's
- Mental Health HPSA's
- Border Mental Health Service Area
 - Catchment Area 1
 - Northeast Mental Health Service Area
 - South Central Mental Health Service Area
 - Cibola County Service Area
 - Dona Ana County Service Area
 - Plains Mental Health Service Area
 - Rio Arriba County Service Area
 - Southeastern Catchment Area
 - Torrance County Service Area
 - Taos County Service Area
 - Valencia County Service Area
 - Non-Designated Area

HEALTH OF NEW MEXICO CHILDREN: MEDICAID & EPSDT

National Performance Measure 14: Percent of Potentially Medicaid-Eligible Children Who Have Received a Service Paid by the Medicaid Program

Healthy People 2010: This measure is related to 1.4b, to increase the proportion of children and youth age 17 years and under who have a specific source of ongoing care to 96% (baseline 93% in 1997); and to 1-6, to reduce to no more than 7% the proportion of families that experience difficulties or delays in obtaining health care or do not receive needed care for one or more family members.

The chart below summarizes NM performance on this indicator. A detailed discussion of its component parts follows.



- ❖ The potential eligibles that received a service gained 10 percentage points, and reflects both an increased enrollment and actual use of Medicaid-paid services.
- ❖ The potential eligibles who enrolled has increased 5 percentage points from FY01-04, this is consistent with the increasing numbers of children enrolled in Medicaid and the decrease in numbers of uninsured children (see NPM 13).
- ❖ The percent of eligibles that received a Medicaid paid service also increased about 5 percentage points. This report reflects several different dimensions of enrolling and then actually using the Medicaid card, only some are listed here:

- Not all children who have a Medicaid card actually use it for a wide variety of reasons
- Children living in some geographic areas may have trouble to find a doctor who accepts Medicaid
- Billing systems in public health services – and possibly private provider entities - do not always capture a paid service
- The number of potential eligibles includes immigrant children who have to be in the US 5 years before they can apply for Medicaid (even though their parents are working and paying taxes)
- There are working poor, families who could but do not enroll in Medicaid,
- There continue to be areas of state where families report difficulties such as unpleasant enrollment processes.
- On the positive side, the presumptive eligibility-Medicaid on-site application assistance (PE-MOSAA) procedure is implemented in LHOs and by contractors as well.

DATA BACKGROUND, CHILDREN WHO ARE POTENTIALLY ELIGIBLE FOR MEDICAID IN NEW MEXICO:

Children age 0-20 at or below 185% of the Federal Poverty Level (FPL) are potentially eligible provided they meet all other criteria. From 1998-2003, NM used an estimate of 56.3% of children developed by NM Voices for Children (the NM Kids Count organization) that was based on data from the NM Tax and Revenue Department. Data from the NSCH in 2003 found that an estimated 49-50% of NM children were at or below 185% of poverty. This is close to the Tax and Revenue estimate; yet the Tax and Revenue estimate was all New Mexicans including lower income people without telephones. There is no evidence to suggest the rate has decreased; unemployment has increased and the overall poverty performance for the state has not improved.

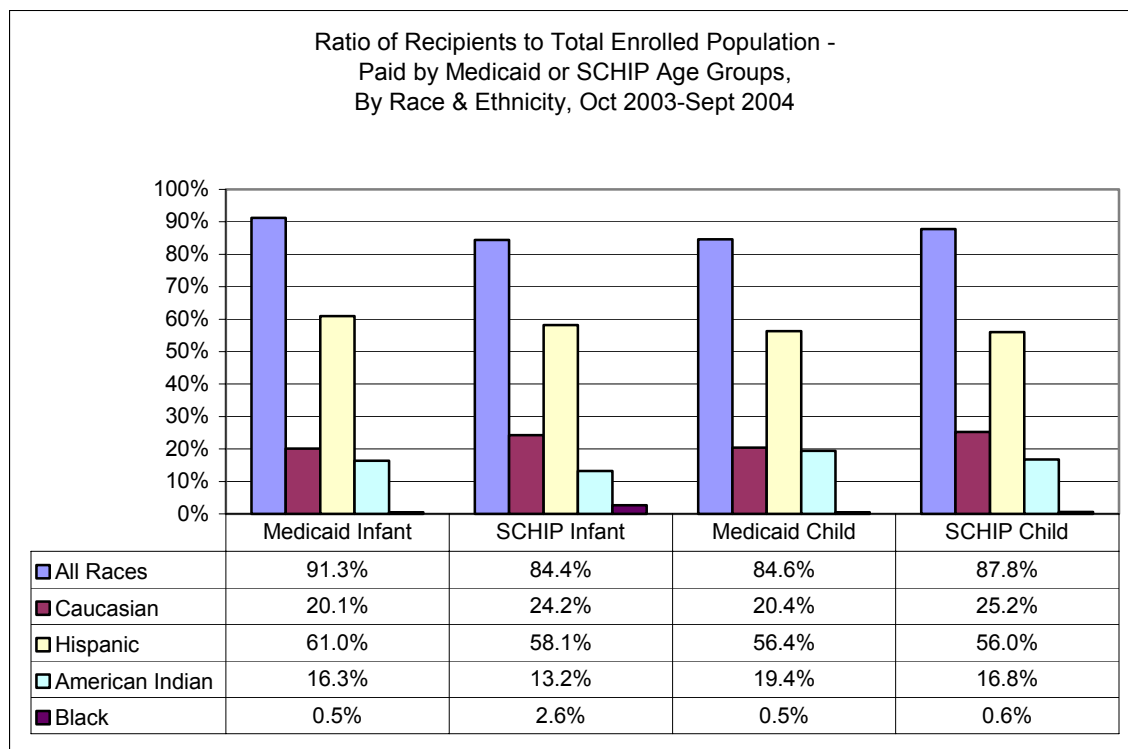
Estimate of Children Potentially Eligible for NM Medicaid, Age 0-20 Years, Using NM Tax and Revenue Estimate of 1998 for Population below 185% FPL					
	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004
NM Census Estimate All Children Age 0-20 Years	592,521	599,238	600,615	601,223	601,223
Estimate of Children <185% Using NM Tax & Revenue Estimate	56.3%	56.3%	56.3%	56.3%	56.3%
Estimate of Potentially Eligible	333,590	337,371	338,146	338,489	338,489

The table below shows the detail needed to assess this indicator. It is somewhat difficult to work with because intercensal estimates (after 2000) are just that, the best estimate.

Data for the number of eligibles and recipients is from Medicaid.

Estimates of NM Children Who Are Eligible to Apply for Medicaid, of Eligibles Who Received a Service, and of Potential Eligibles Who Received A Service, NM FY 2001-2004						
	Potential Number	Eligible Number	Recipient Number	% Potential Eligible Who Enrolled	% Eligibles Who Received Medicaid Paid Service	% Potential Eligibles Who Received a Medicaid Paid Service
2000-01	333,589	296,894	235,136	89.0%	79.2%	70.5%
2001-02	337,370	306,330	267,063	90.8%	87.2%	79.2%
2002 to 03	338,146	311,013	265,487	92.0%	85.4%	78.5%
2003 to 04	338,489	321,074	272,894	94.9%	85.0%	80.6%

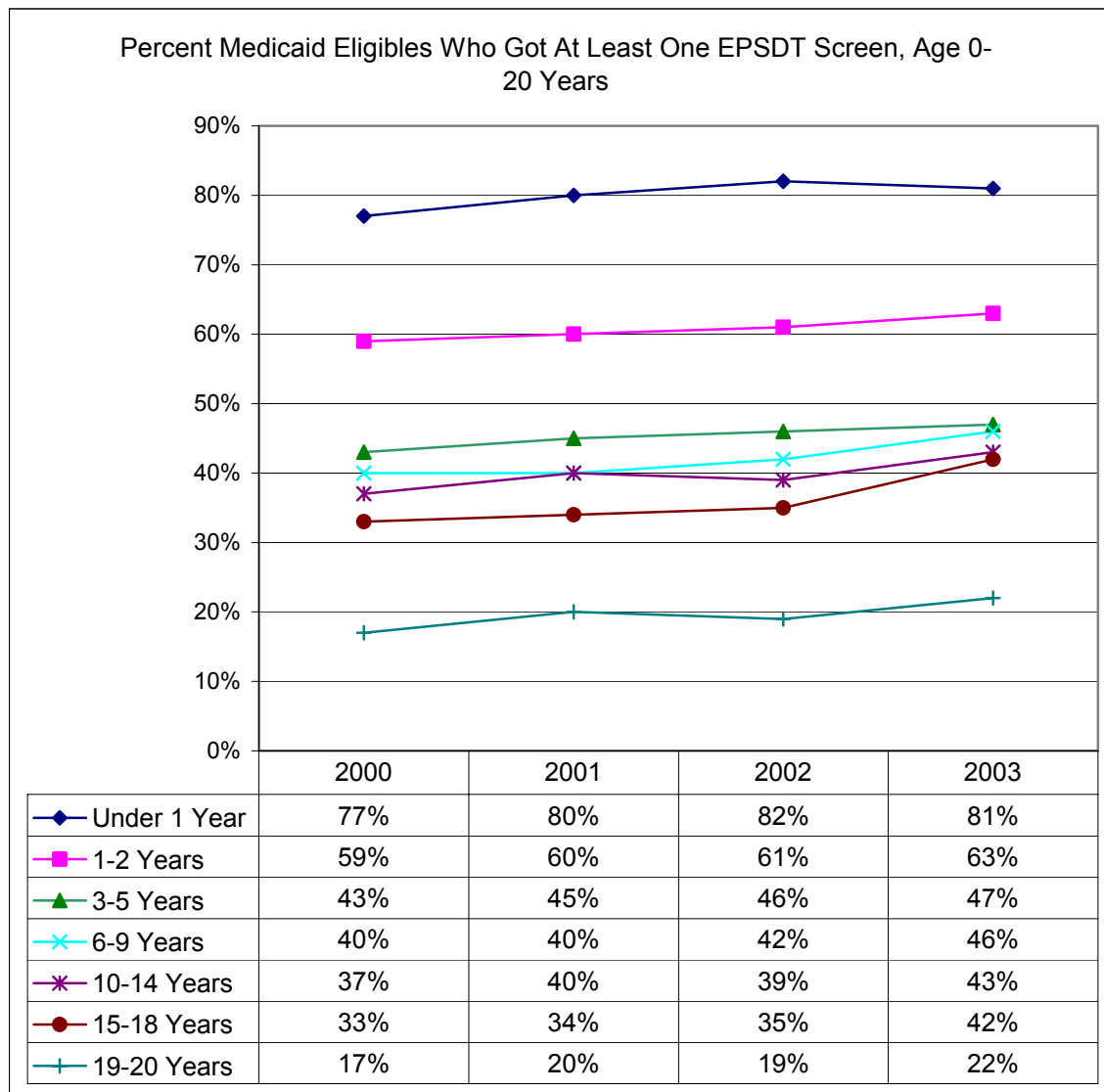
The table below shows the race-ethnicity composition of Medicaid and SCHIP population groups. Thus, 91.3% of All Races of Medicaid enrolled infants received a paid service; 20.1% were Caucasian; 61% were Hispanic; 16.3% were American Indian and 0.5% were Black.



Source: Medical Assistance Program, NM Human Services Department

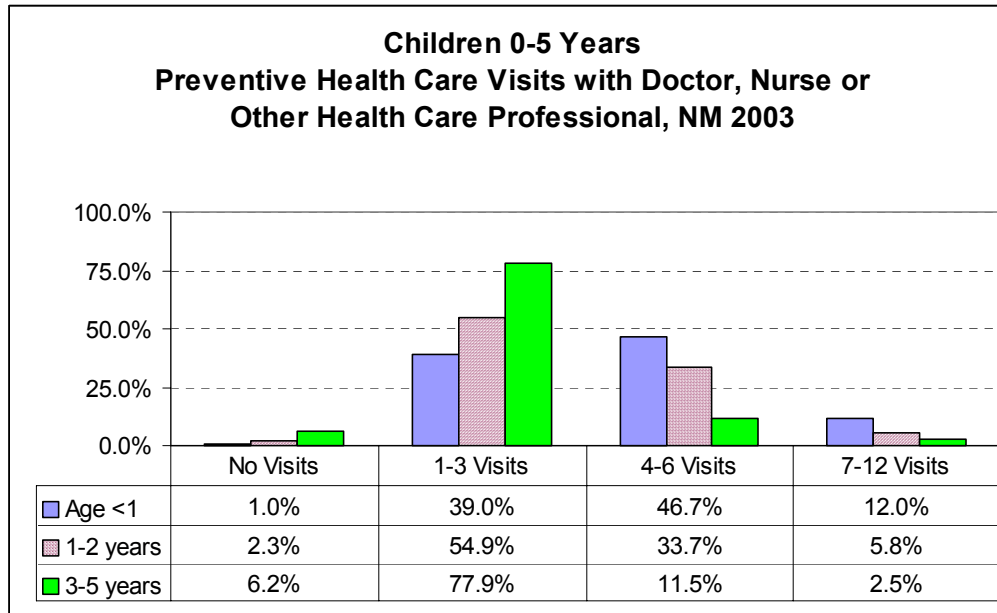
Health Systems Capacity Measure 02 and 03: Medicaid and SCHIP Eligible Children and Early Periodic Screening, Diagnosis and Treatment (EPSDT)

Actual use of EPSDT services by NM children varied significantly by age groups, with some increase in the period 2000-2003. This chart does not imply that the number of annual services received were according to recommendations of the American Academy of Pediatrics for children's preventive services.



Data Source: HCFA 416 Report of EPSDT, New Mexico Human Services Dept. There is a critical need to work to strengthen the state's resources for doing EPSDT for children over one year of age, because of the mounting evidence of developmental and behavioral problems among young children age 1-5 years; and the need to screen all

children for mental health and developmental status. The National Survey of Child Health asked about all children; this table provides an indication of the number of preventive health visits a child may have received.

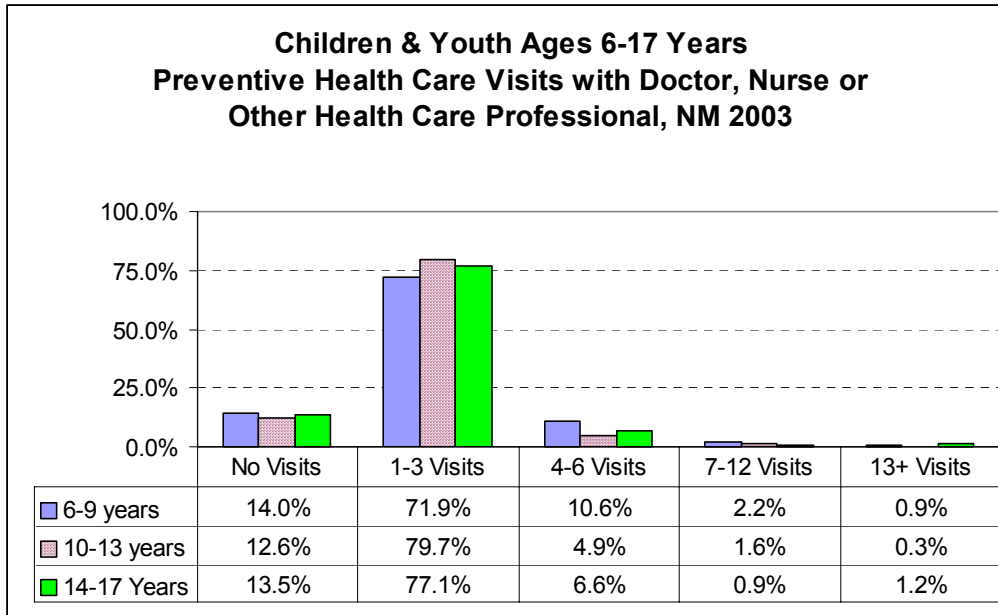


Data Source: Centers for Disease Control & Prevention, National Center for Health Statistics, State & Local Area Integrated Telephone Survey, National Survey of Children's Health, 2003. Analysis by NM MCH Epidemiology

The NSCH can be used to evaluate use of preventive care by Medicaid v. non-Medicaid-paid services. More detailed analysis is needed to see where improvements need to be made.

Number of Preventive Care Visits to Doctor, Nurse or Other Health Care Worker for Physical Exam or Well Child Care, by Medicaid/S-CHIP or Other Coverage, NM 2003						
	None	1-3 Visits	4-6 Visits	7-12 Visits	13+ Visits	Parent Didn't Know
Not on Medicaid or S-CHIP	9%	75%	12%	2%	1%	1%
On Medicaid	10%	68%	16%	4%	1%	1%
Parent Didn't Know Type Coverage	23%	64%	13%	0%	0%	0%
Total Visits, On Average	10%	72%	14%	3%	1%	1%

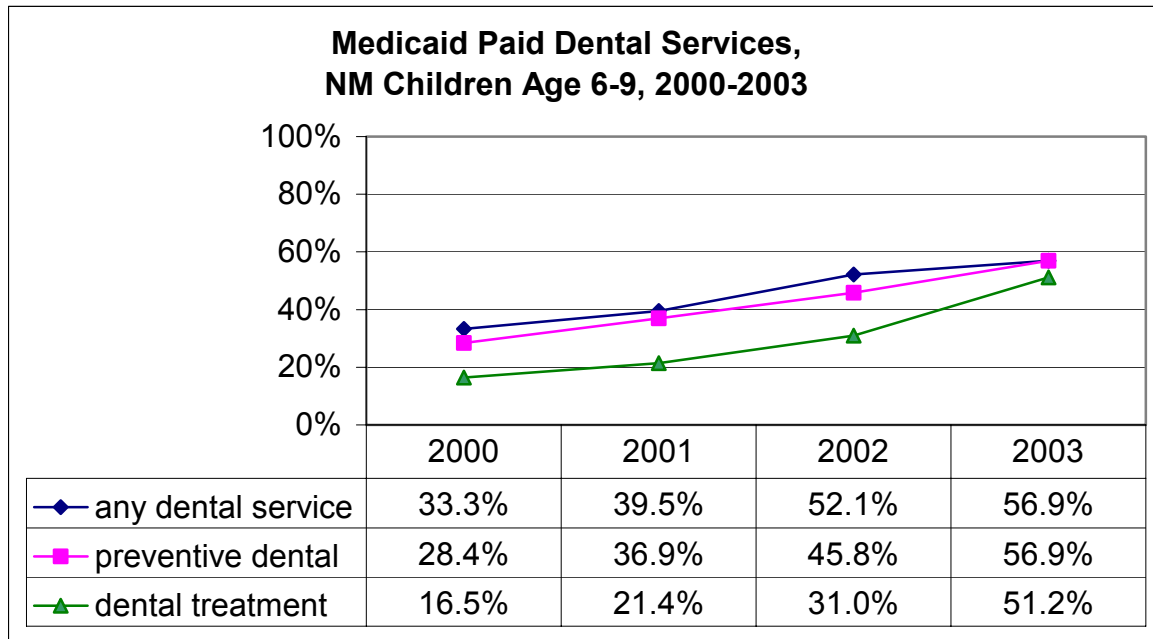
Data Source: Centers for Disease Control & Prevention, National Center for Health Statistics, State & Local Area Integrated Telephone Survey, National Survey of Children's Health, 2003. Analysis by NM MCH Epidemiology



Data Source: Centers for Disease Control & Prevention, National Center for Health Statistics, State & Local Area Integrated Telephone Survey, National Survey of Children's Health 2003. Analysis by NM MCH Epidemiology.

Youth are less likely to receive preventive services – to be more specific, EPSDT services if they are on Medicaid. The NSCH data suggests the need for more analysis because fewer than 40% of young people over age 6 were reported by Medicaid to have received an EPSDT service.

Gaps in oral health services for mothers and infants reached near crisis proportions in recent years. The Medicaid program has made significant strides in serving NM children through increasing the reimbursement schedule and recruiting additional dentists who would accept Medicaid payment.



Oral health for women in pregnancy is a critical service, and for women with oral health disease, it can reduce the risk of untoward pregnancy and infant outcomes. In 2003-2004, there were 17,068 women whose prenatal care and/or delivery was paid by Medicaid. Of these, 14.13% or 2,412 , women received a dental service during pregnancy. This compared favorably with FY03 when 14.19% of pregnant women received a dental service paid by Medicaid. The state “maintained ground”. This service will be monitored in the coming period because one of the largest MCOs, among the first to offer dental care to pregnant women, had to discontinue this expanded service due to cuts in Medicaid.

HEALTH OF NEW MEXICO CHILDREN: IMMUNIZATIONS

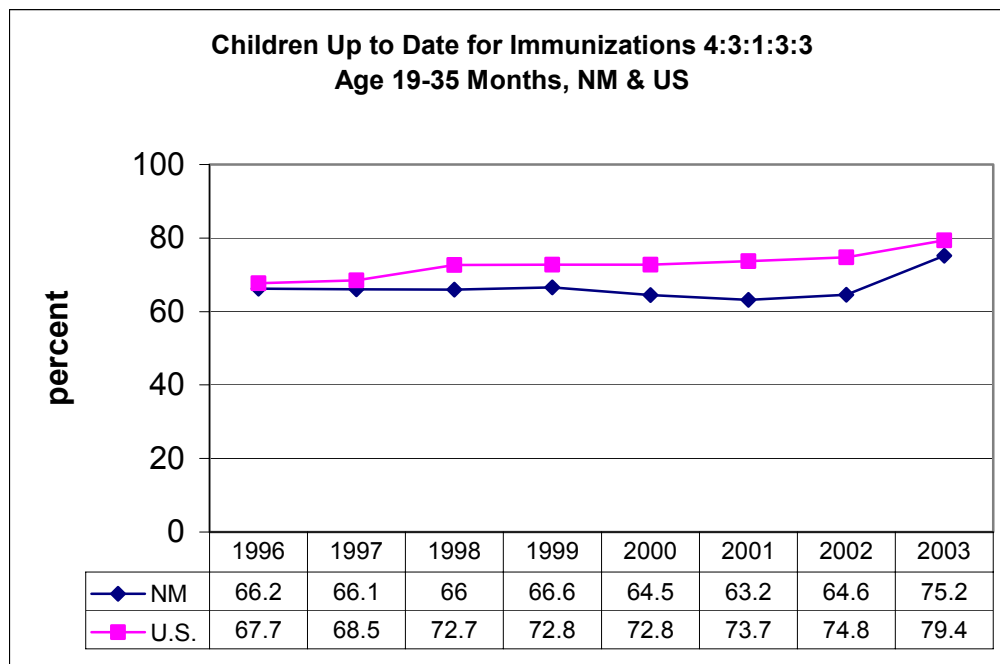
Performance Measure 07. Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertusis, Haemophilus Influenza, Hepatitis B.

Routine immunization against infectious diseases of childhood is, along with basic sanitation, a hallmark of public health and one of the most effective means of preventing widespread outbreaks of disease. Immunization coverage is an important indicator of health care accessibility and quality.

The Healthy People 2010 goal for the nation is 90% immunization coverage among children ages 19 – 35 months old, for five childhood vaccines: diphtheria, tetanus, pertussis (DTP); polio (OPV); measles, mumps, rubella (MMR); haemophilus influenza (Hib); and hepatitis B. The completed vaccine series is referred to as the 4:3:1:3:3 series, based on the number of age appropriate doses recommended for each vaccine.

♦ From 1995 - 2000, the percentage of New Mexico children ages 19-35 months that have completed the 4:3:1:3:3 series has increased 30%.

In 2003, an estimated 75.2 % of toddlers 19-35 months had all their needed immunizations. This represented an increase of 14% in the last year-and-a- half.



At the end of 2004, the NM performance for the complete series was nearly the same as the nation. This graph also shows the performance for series that include fewer vaccines and the challenges faced not only by providers but by parents as well, to complete the full recommended series of 4:3:1:3:3:1.

Estimated Vaccination Coverage Among Children 19-35 Months of Age, US and NM, National Immunization Survey, Q3/2003 - Q4/2004				
	4:3:1^{§§}	4:3:1:3|||	4:3:1:3:3^{†††}	4:3:1:3:3:1^{***}
US National	83.1±0.8	82.3±0.9	80.5±0.9	74.5±0.9
New Mexico	80.4±5.6	80.1±5.6	77.9±5.8	74.2±6.1

§§ Four or more doses of DTP, three or more doses of poliovirus vaccine, and one or more doses of any MCV.

||| Four or more doses of DTP, three or more doses of poliovirus vaccine, one or more doses of any MCV, and three or more doses of Hib

††† Four or more doses of DTP, three or more doses of poliovirus vaccine, one or more doses of any MCV, three or more doses of Hib, and three or more doses of HepB

***Four or more doses of DTP, three or more doses of poliovirus vaccine, one or more doses of any MCV, three or more doses of Hib, three or more doses of HepB, and one or more doses of varicella

††† % ± 95% Confidence Interval

Ongoing and future initiatives whose aim is improvement of childhood immunization coverage include: the 'Done By One' accelerated childhood schedule, the new 'Health Passport' immunization record, the Governor's childhood immunization-promoting 'Hallmark' greeting sent to new parents, the SHOT Team Provider Quality Improvement Initiative, and the New Mexico Statewide Immunization Information System, a secure, web accessible immunization database that will go live in the Summer of 2005.

The 'Done by One' program was originally developed by the NM Medical Society's Clinical Prevention Initiative in collaboration with DOH. The program is data-driven based on gaps that were identified in the effectiveness of NM's immunization efforts. 'Done by One' was announced in April, 2003 with a soft-sell introduction and was

recommended as one of several alternative methods of getting all children immunized. The materials to promote 'Done by One' are available from the NM Immunization Program, and included chart flags, refrigerator cards, immunization passports and posters.

It is the fourth DtaP and the third Hepatitis B shots are the immunizations most frequently not delivered. Immunization staff have inferred from the data that families comply well with the immunization schedule and physician visits during the first year of a child's life, but by the time the child reaches 15 to 18 months of age, compliance drops off significantly. These same immunizations also have a large "window of discretion" as to when providers may decide to give them.

The "Done by One" (DBO) campaign is intended to address this problem of children failing to get the later shots in their infant immunization series. Problems arising from children failing to get shots include an increase in pertussis cases. A problem with the "Done by One" (DBO) schedule is that three shots are required at each 2, 4 and 6 months of age. Currently five shots are required at 12 months of age. Next year the latter will be reduced to four shots by approval of a new covalent vaccination.

Data from the program so far show that the private sector has embraced the program less enthusiastically than public clinics. However, the private providers had higher immunization rates to begin with, and did not necessarily see the need to adopt the accelerated schedule, whereas publicly funded clinics had lower rates and have seen the DBO schedule as a method of improving poor rates. Almost every practice has improved in the past two years, even those not using DBO. The DBO requires a major effort on the part of providers, even if vaccine shortages don't complicate things.

Among the remaining barriers to timely immunization are:

- inconsistent or shifting medical care coverage
- cost
- provider "missed opportunities"
- poor documentation, and
- an increasingly complex immunization schedule

Additional issues identified by FHB staff in the needs assessment period:
Gaps and issues to address are:

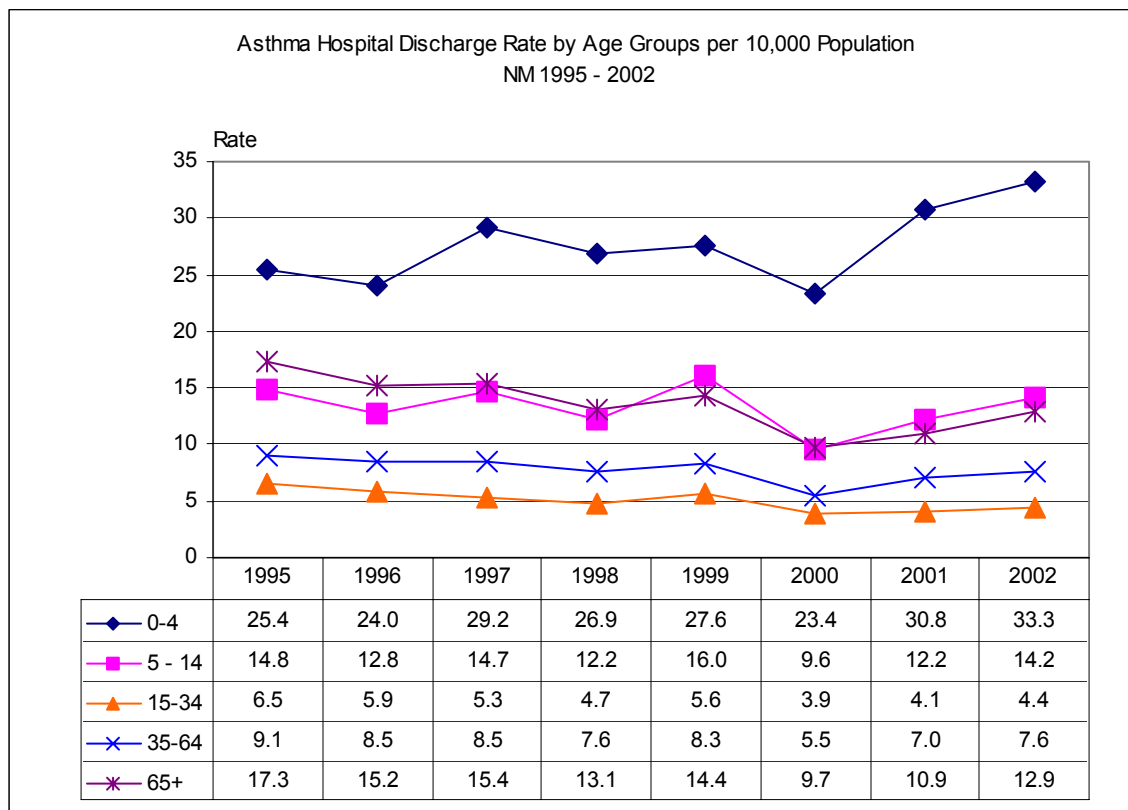
- ❖ A workforce to serve all populations and educate to the advantages of receiving immunizations.
- ❖ Immunization data from MCOs is lacking.
- ❖ The State is not able to track immunizations if clients do not utilize a medical home.
- ❖ Keeping a complete record is difficult if immunizations are given where they are not tracked or the child's parent or guardian does not keep a record
- ❖ Immunization rates are lower for American Indians, African Americans, and Hispanics
- ❖ Immigrant children who received immunizations in Mexico but who arrive without their immunization records, children between 12-35 months

HEALTH OF NEW MEXICO CHILDREN: ASTHMA & ACCESS TO PRIMARY CARE

Health Systems Capacity Indicator: The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 – 493.9) per 10,000 children less than five years of age

Healthy People 2010 Goal: To reduce hospitalizations for asthma in children 0-5 to no more than 23 per 10,000 population.

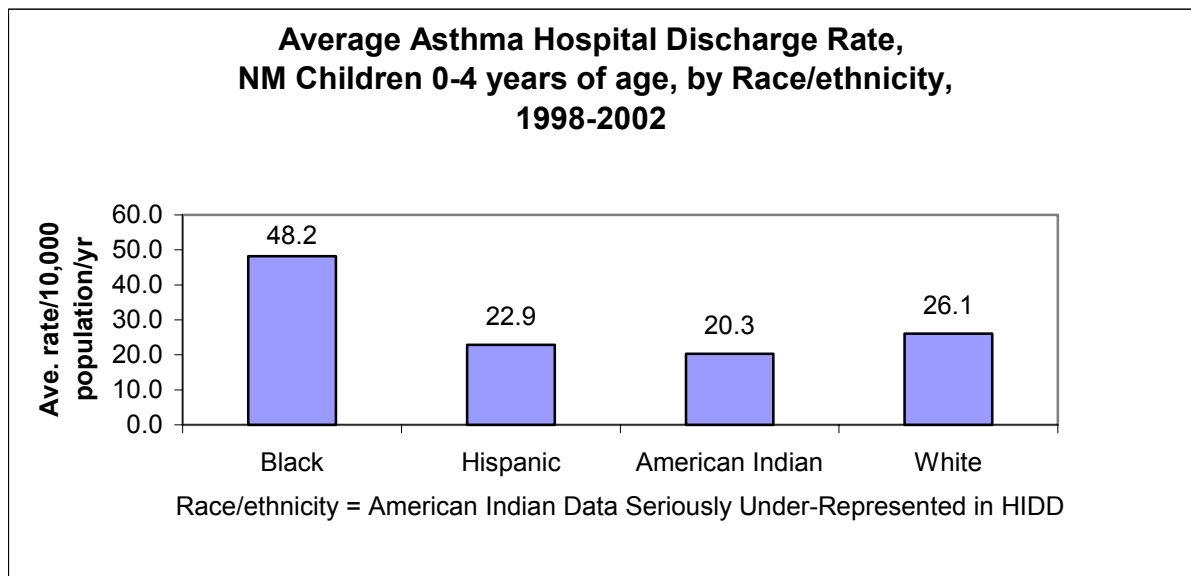
Asthma is an ambulatory care sensitive (ACS) condition: increased asthma hospitalization rates may be a consequence of inadequate outpatient management and/or access to a medical home; adequate outpatient care reduces hospitalizations. The graph below shows asthma discharges for all population groups in NM. It is particularly interesting because between 1995 and 2002, the rate of discharges for children 0-4 years of age increased from 25.4 to 33.3/10,000. The rate in all other population groups decreased. The rate for children age 0-4 years was 50% greater than for ages 5-14 years in 2002.



Source: NM Hospital Inpatient Discharge Diagnosis (HIDD) of the NM Health Policy Commission, analysis performed by G. Hubbard, Asthma Program, ERD/NM DOH

Gaps and Disparities: In previous years, analysis for year 2000 hospital inpatient discharger data revealed the following: Toddlers age 1 were more likely to be hospitalized than those age 3-4, and the rates for all children under age 4 were higher than for children ages 5 to 9 years. American Indian children age 0-4 had even higher rates of hospitalization for asthma than Hispanic or white children. Data for infants under one year are difficult to assess because of diagnostic difficulties in that age. More children were hospitalized who had asthma, but not as the primary diagnosis at discharge.

Five years of data made analysis by race-ethnicity possible. As seen below, the rate for Black children was over twice that of other groups. Because the hospital inpatient discharge data (HIDD) of the NM Health Policy Commission does not include I.H.S. hospitals serving Navajo and Pueblo populations, data for Native American children are under-represented.



The next table shows the average annual rate of discharge for asthma, all ages, 1998-2002 and by NM counties. The top two counties, Curry and Lea, are in the southeastern corner

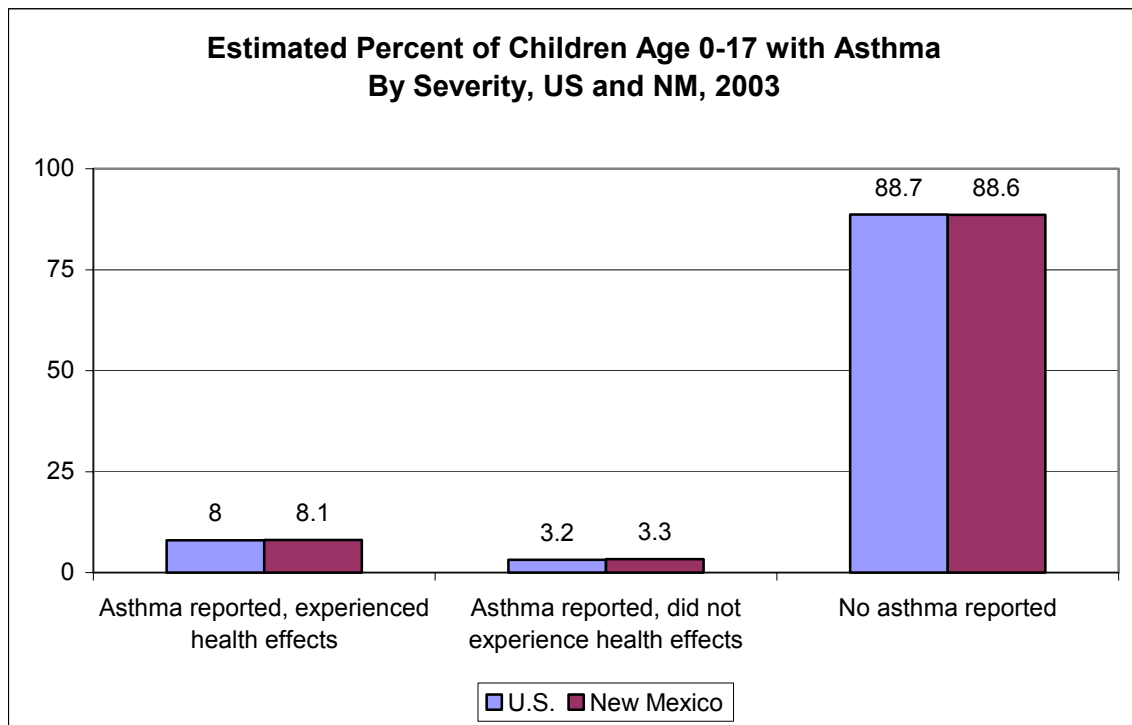
of the state where there are an inadequate number of providers who accept payment by Medicaid and a high proportion of uninsured.

Average annual rate of asthma hospital inpatient discharges in NM In rank order by county, 1998-2002			
County	Percent	County	Percent
Curry	30.5	Cibola	8.5
Lea	26.0	Valencia	8.2
Colfax	16.8	Torrance	8.1
Roosevelt	15.6	Sierra	8.0
Luna	14.8	Sandoval	7.7
Eddy	14.4	Guadalupe	7.6
Chaves	14.3	Bernalillo	7.6
DeBaca	9.9	Otero	7.5
Hidalgo	9.9	Union	7.4
San Juan	9.9	Dona Ana	6.9
San Miguel	9.7	Santa Fe	6.5
Quay	9.6	Mora	5.5
NM	9.3	Los Alamos	4.7
Socorro	9.3	Lincoln	4.5
Grant	9.2	Mckinley	3.7
Rio Arriba	9.2	Catron	2.9
Taos	8.7	Harding	0.0
Analysis by G. Hubbard, Environmental Epidemiology, NM DOH			

Asthma is one medical condition that may be used to measure the extent to which children are receiving quality disease preventive care and health promotion education. Access to and use of appropriate medical care can often prevent severe episodes of asthma.

Exposure to environmental risks: Tobacco smoke is associated with childhood asthma. In New Mexico, an estimated 27% adults smoke. An estimated 61.4% of students in grades 9-12 reported being exposed to second hand smoke in the past 7 days in 2003; nearly 30% of students in grades 9-12 reported smoking in the past 30 days^{viii}. The exposure of youth to second hand smoke may be a useful to estimating exposure to younger children. An estimated 6.9% of infants were reported to be exposed to second hand smoke; while 13.6% of new mothers reported being current smokers which may imply that mothers and others smoke outside the home.

Asthma Morbidity: According to the CMS Program, asthma is the leading diagnosis among children served by the CMS program; in 2003 there were 493 children of ~5,000 total. The newly released National Survey of Children's Health (NSCH) of 2003 affords a profile of asthma prevalence in NM children age 0-17 and selected comparisons to the national experience, based on a parent's reply to the telephone survey. The survey asked if children had asthma, and if they had asthma one or more asthma-related effects during the past 12 months. This summary will use the term "asthma with health effects" to refer to these children who had asthma unless specified otherwise. The source for this portion of the asthma report was adapted from the Child and Adolescent Health Measurement Initiative (2005). National Survey of Children's Health, Data Resource Center on the Child & Adolescent Health website, retrieved June 2005 from www.nschdata.org.



Data Source: Centers for Disease Control & Prevention, National Center for Health Statistics, State & Local Area Integrated Telephone Survey, National Survey of Children's Health, 2003.
Analysis by NM MCH Epidemiology

The estimated prevalence of NM children with asthma with health effects increased with age:

- ❖ 5.1% ($\pm 2.5\%$) for age 0-5 years, an estimated 8,058 children
- ❖ 7.6% ($\pm 2.7\%$) for age 6-11 years, an estimated 11,956 children
- ❖ 11.2% ($\pm 2.9\%$) for age 12-17, an estimated 19,776 children

Boys were more 1.8 times more affected than girls in NM, 1.4 times more for all US children; the NM and US estimates were similar. The NM estimates by gender:

- ❖ 10.5% ($\pm 2.4\%$) of boys with asthma related health effects
- ❖ 5.6% ($\pm 2\%$) of girls with asthma related health effects

Large differences were reported by race-ethnicity of children. Black children were more affected than all NM children although the rate was unstable due to small numbers; in the US the rate was 12.6 and more stable – suggesting that Black children are 1.5 times more affected; similarly the burden was greater for Native Americans and others, 1.3 times. Hispanic children had the same prevalence as all NM children and White non-Hispanic children were less affected than all children.

- ❖ 18.6% ($\pm 17.2\%$) for Black children (use US estimate)
- ❖ 10.2% ($\pm 7.4\%$) for other race that included Native Americans, unstable estimate
- ❖ 8.1% ($\pm 2.1\%$) for Hispanic White children
- ❖ 6.8% ($\pm 2.1\%$) for White non-Hispanic children

In NM and in the US, children with special health care needs were 11.3 times more affected by asthma than children with no special needs. The prevalence of New Mexico children with asthma who reported one or more asthma related health effects during the past 12 months was:

- ❖ 32.9% ($\pm 7.4\%$) for NM children with special health care needs
- ❖ 2.9% ($\pm 1.1\%$) for NM children with no special health care needs

The federal poverty level (FPL) of the household was directly associated with asthma related health effects among US children: the lower the poverty level, the greater the prevalence of asthma related health effects. This association was less stable in the NM data for reasons that are not clear. The NM prevalence of asthma with related health effects by FPL in NM:

- ❖ 9.8% ($\pm 4.4\%$) of children in households $< 100\%$ of the FPL
- ❖ 6.6% ($\pm 2.9\%$) of children in households at 100-199% of the FPL
- ❖ 9.1% ($\pm 2.9\%$) of children in households at 200-399% of the FPL
- ❖ 8% ($\pm 2.9\%$) of children in households at 400% or higher of the FPL

Health insurance coverage was also associated with asthma with health effects among US and NM children. The NM prevalence of asthma with related health effects by insurance coverage in NM:

- ❖ 8.8% (± 2.8) of children with public insurance
- ❖ 7.7% (± 1.8) of children with private insurance
- ❖ 7.6% (± 6.3) of children with no health coverage, uninsured

For US children, the percent who had stayed overnight in a hospital because of asthma was 0.5% (± 0.4) and 11.9% (± 0.3) with asthma were never hospitalized. Estimates for NM were not published due to small numbers.

HEALTH OF NEW MEXICO CHILDREN: ORAL HEALTH

National Performance Measure 9, The percent of third grade children who have received protective sealants on at least one molar tooth.

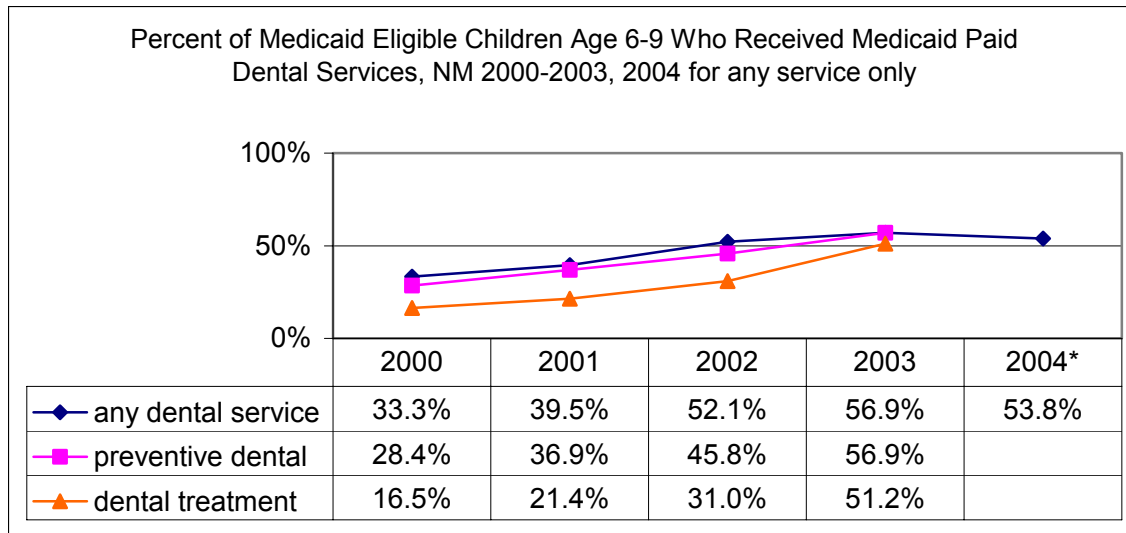
Dental caries affects two thirds of children by the time they are 15 years of age.

Developmental irregularities called pits and fissures are the sites of 80-90% of childhood caries. Sealants selectively protect these vulnerable sites, which are found mostly in permanent molar teeth. Targeting sealants to those at greatest risk of caries has been shown to increase their cost effectiveness. Sealants may also be a surrogate indicator of dental access, oral health promotion and preventive activities, and a suitable means to assess the linkages that exist between the public and private services delivery system.

Healthy People 2010 Increase the percent of 8-year-old children receiving dental sealants on their permanent molar teeth by 50% from a 1998 baseline of 25%. The NM dental sealant target was set at 50% based on the Health People 2000 goal of 50%.

In 2003, an estimated 76.5% (CI 73.7, 78.6) of NM children <18 years of age had insurance that helps to pay for routine dental care that included cleaning, x-ray and exam (NSCH 2003). The survey did not ascertain if sealants were part of the package; nevertheless, the data are promising.

Medicaid Paid Dental Services: The state initiative to increase the amount reimbursed to dentists



Source: 2000-2003, HCFA-416, Annual EPSDT Report for New Mexico

And to increase the number of dentists who accept Medicaid-paid clients is having an impact. The table below shows the actual numbers of children served by Medicaid between 2000-2003, based on the EPSDT report. The 2004 EPSDT report has not yet been officially released; thus program data were available for simple count of any service. Note that the numbers of dental treatments have increased significantly. Both the number of eligible children and recipients in 2004 increased significantly, the proportion with a paid service decreased. This may indicate that the state initiatives to increase access to dentists who accept Medicaid may not be keeping up with the needs.

Medicaid Dental	2000	2001	2002	2003	2004
Total eligible age 6-9	57,065	59,052	60,754	62,733	77,707
Any dental service	18,992	23,312	31,668	35,721	41,815
Preventive dental	16,228	21,801	27,819	35,712	.
Dental treatment	9,388	12,618	18,814	32,123	.

Improvements reflect the work of the DOH Dental Program and Medicaid to increase the payments to dentists and to increase the number and distribution of dentists serving Medicaid eligible children

In order to ensure adequate numbers and distribution of school-based sealant providers and to improve children's access to dental care in general, the Office of Dental Health

- Works with the NM Dental Board and NM Oral Health Council to increase access for dental care
- Supports public-private partnerships to increase dental services to low-income children.
- Serves low-income families who don't qualify for Medicaid but need dental treatment.
- Works in partnership with private school based providers to increase the number of children receiving preventive dental treatment.

- Targets low-income children in under-served areas; schools with 50% or greater participation in the free or reduced lunch program.

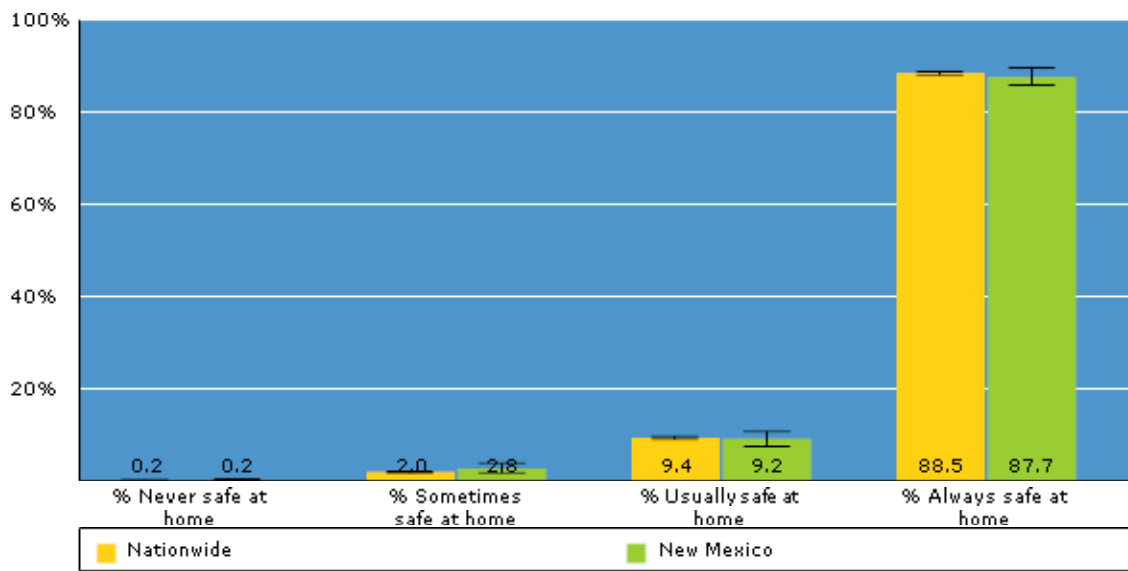
Data on dental sealants are from the Office of Dental Health, survey of children in schools with subsidized lunch programs, assuming such schools would have more Medicaid eligible children than non-subsidized schools. A survey done in the year 2000 showed that 48% of the target population had received sealants. No survey has been done subsequently although the dental program reported the same level of effort, therefore the same level of coverage. Coverage in the southeastern corner of the state continues to be lower, due largely to the absence of dentists willing to work with the program, or to provide Medicaid-paid services.

A PROFILE OF CHILDREN'S SAFETY

In order to achieve optimal development, all children need to live in an environment where they feel safe and have supportive relationships among family and neighbors. They also need to feel and be safe from exposure to all forms of violent behaviors. This is a priority of the NM Title V MCH Program, and is related to priorities of the agency members of the NM Children's Cabinet and the Early Childhood Comprehensive Systems program.

The National Survey of Children's Health in 2003 provides an overview of what NM parent's said about how safe their children were at home and in their neighborhood.

PARENT REPORT OF HOW SAFE CHILDREN WERE AT HOME, NM AND US, 2003



Citation: Child and Adolescent Health Measurement Initiative (2005). *National Survey of Children's Health*, Data Resource Center on Child and Adolescent Health website. Retrieved June 2005 www.nschedata.org

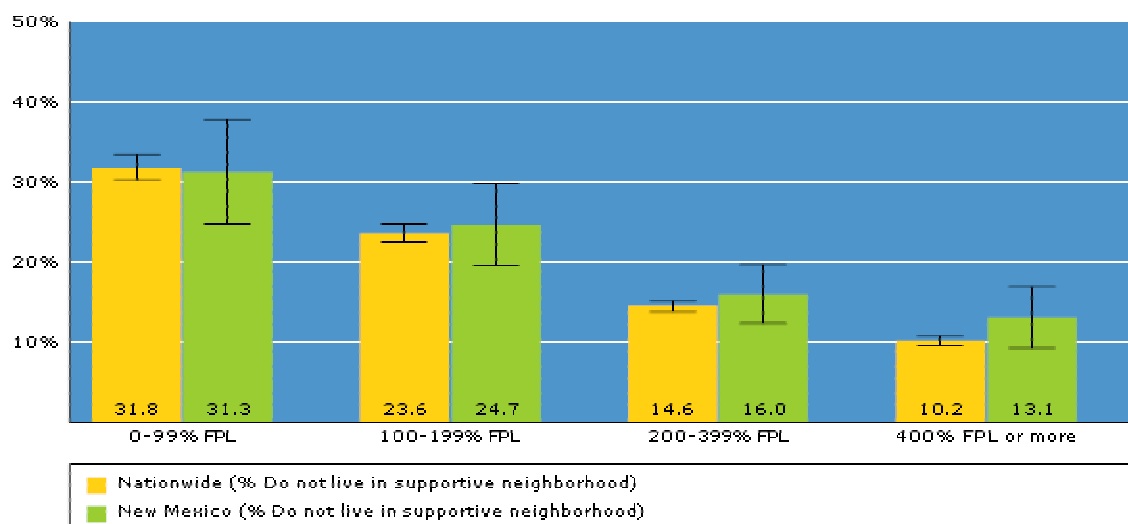
The majority, nearly 88%, reported children to be always safe at home and there were an estimated 12% who were not. The NSCH data doesn't ascertain why parents thought their children were not safe at home, and thus does not reflect directly being safe from violence alone but other risks as well – such as unintentional injury. Bear in mind that the tip of the iceberg would be actual abuse or witnessing violence that are reported per 1,000 population – and in 2003 such risks were in the range of 11-12/1,000 children.

Of the 2.8% of households in which parents said their children were safe at home only sometimes, there was an inverse direct relationship with the poverty status of the household from 6.8% below 100% FPL; 1-3% for households 100-300% of FPL and 0.4% at 400% or higher; and a direct relationship with age of child, from 1.5% among children age 0-5 years, 2.4% among children age 6-11 and 4.4% among children 12-17 years of age.

About 50% of both NM and US parents reported their child was always safe in the neighborhood, an estimate that did not vary by federal poverty level. NM estimates for factors associated with a supportive neighborhood by federal poverty level are found at the end of this section. In summary, the percent of these factors for all NM parents, by a parent's views were (percent was rounded):

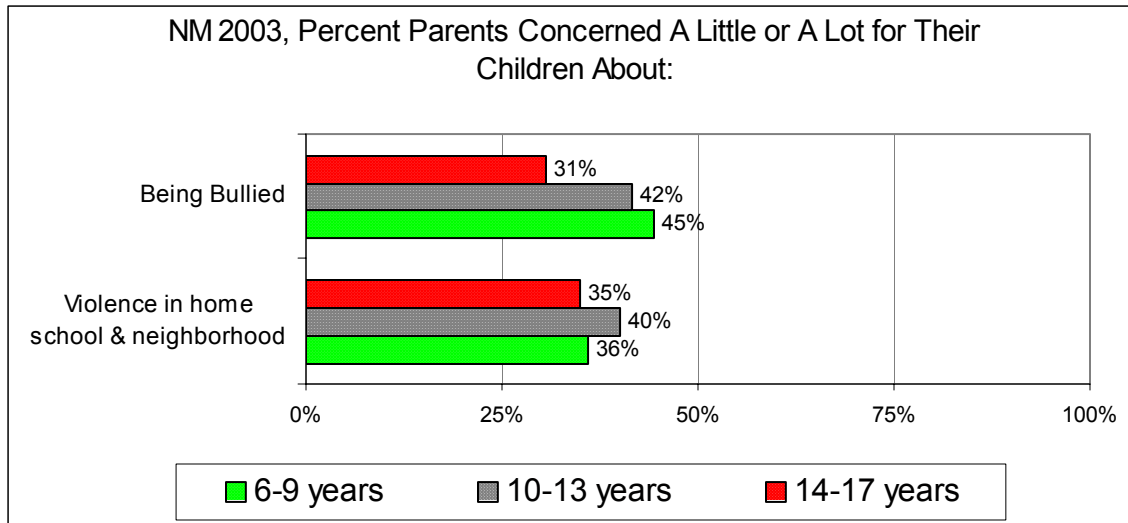
- ❖ People in this neighborhood help each other out: 78.6% agreed and 19.3% disagreed
 - ❖ We watch out for each other's children: 82.3% agreed and 15.2% disagreed
 - ❖ There are people I can count on: 82.5% agreed and 15.6% disagreed
 - ❖ If a child were outside playing and got hurt or scared, there are adults nearby who I trust to help my child: 85.7% agreed and 11.9% disagreed
 - ❖ There are people in this neighborhood who might be a bad influence on my child: 47.9% agreed and 48.4% disagreed
- The effect of poverty on the degree to which a neighborhood is supportive provides some documentation to support program prioritization efforts.

PERCENT OF CHILDREN WHO LIVE IN NEIGHBORHOODS THAT DID NOT HAVE SUPPORTIVE QUALITIES BY FEDERAL POVERTY LEVEL:



Citation format: Child and Adolescent Health Measurement Initiative (2005). *National Survey of Children's Health*, Data Resource Center on Child and Adolescent Health website. Retrieved June 2005 www.nschedata.org

An estimated 35-40% of NM parents of children age 6-17 years of age reported that they felt concerned a little or a lot for their children about violence in the home, school and neighborhood; 30-45% were concerned about their children being bullied.



Data Source: Centers for Disease Control & Prevention, National Center for Health Statistics, State & Local Area Integrated Telephone Survey, National Survey of Children's Health, 2003. Analysis by NM MCH Epidemiology

Many of these data can be queried at the Child and Adolescent Health Measurement Initiative (2005). National Survey of Children's Health, Data Resource Center on Child and Adolescent Health website www.nschedata.org. More analysis and reporting will be forthcoming for the NM Title V MCH Program; readers of the needs assessment are encouraged to do their own exploring at the website.

Exposure to violent behavior comes in many forms for young children. It includes witnessing violence to actual violence imposed on children in the forms of abusive and/or neglectful treatment.

CHILDREN WITNESSING VIOLENCE

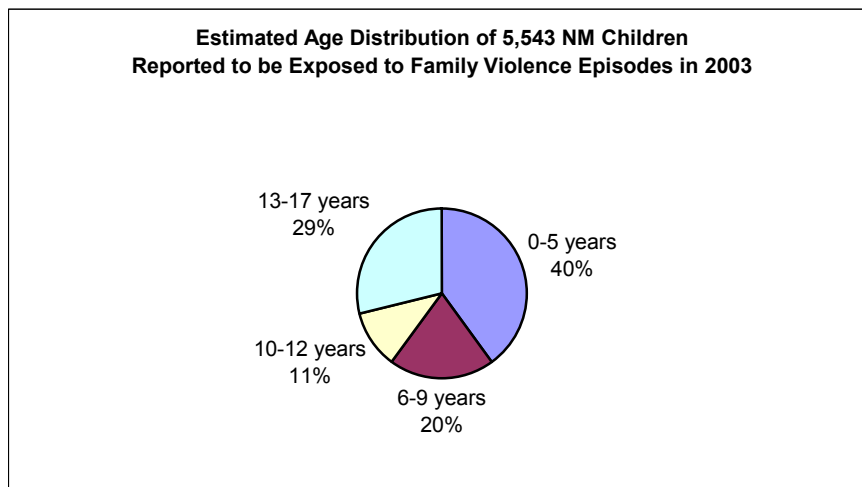
STATE PERFORMANCE MEASURE 4. REDUCE THE NUMBER OF CHILDREN WITNESSING VIOLENCE (EXPOSED TO DOMESTIC OR SEXUAL VIOLENCE) AS EXPRESSED BY THE PERCENT OF CHILDREN PRESENT AT A DOMESTIC VIOLENCE SCENE.

There are no Healthy People 2010 Goals specific to this state measure. Related goals pertain to Healthy People 15-34 to reduce intimate partner violence to less than 3.3 physical assaults per 1,000 persons age 12 and older, and HP 15-33a to reduce child abuse to <10.3 per 1,000 children.

Multiple research studies have shown that the more violence children are exposed to, the more likely they are to be violent themselves, to be labeled as conduct disorder, misuse drugs and alcohol, and to be depressed and suicidal. Males especially are also likely to repeat the cycle of domestic violence when they become teenagers, engaging in physical, emotional and sexual dating violence patterns. Some of the negative effects include emotional distress, somatic complaints, developmental delays or regression, post-traumatic stress symptoms, externalizing behaviors such as aggression and delinquency, and internalizing behavior problems such as anxiety and social withdrawal. These problems may negatively affect overall functioning, social competence, school performance, and future relationships. Multiple victimization experiences (child abuse, sexual abuse, and domestic violence) increase the likelihood of Post Traumatic Stress Disorder (PTSD). In addition, depression, dysthymia, suicide risk and substance abuse may accompany PTSD in domestic violence victims.

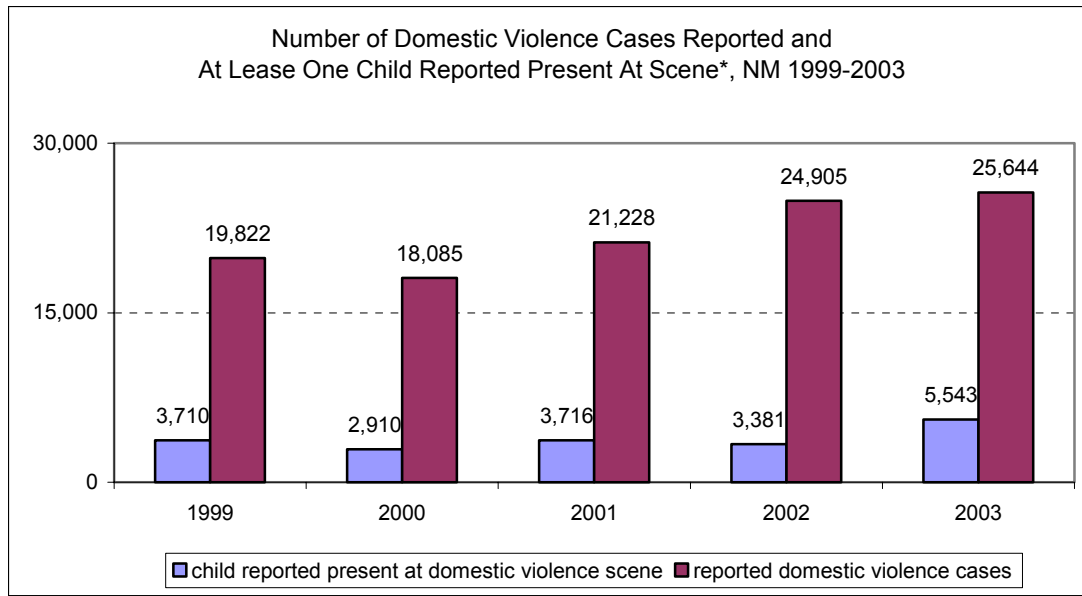
At least 5,543 NM children were exposed to family violence episodes in 2003. Based on age distribution from 2002 data, 40% were under five years of age, 20% were aged six through nine, and 11% were between ten and twelve years of age. Only 29% were adolescents. These data are roughly equivalent to an overall rate of 10.8 children per 1,000 population age 0-17 years in 2003; the estimated rate for the youngest children age 0-5 years was 13.9 per 1,000.

ESTIMATED AGE DISTRIBUTION OF NM CHILDREN, ONE ESTIMATE OF WITNESSING VIOLENCE:



We do not have adequate data to really examine racial/ethnic disparities in children exposed to violence. It is clear that lower income children are disproportionately exposed to violence in the home.

The number of reported domestic violence cases and the number reported with children at the scene increased from 1999-2003 as shown in the table below. Data is considered more reliable as more law enforcement agencies participate in reporting when children are present at a scene. The numbers cited represent only those cases of domestic violence that were reported to the police, where a report was made, and the presence of children noted. The actual numbers of children exposed to violence in the home are thus very much under-reported. There are significant gaps in terms of both quantity and quality of follow up mental health services provided to children exposed to domestic violence.



*Present at the scene as reported by law enforcement. Since not all law enforcement agencies indicate when children are present, this is clearly undercounted.

The percent of domestic violence cases with a report of a child present for the chart above: 1999 = 18.7%; 2000 = 16.1%; 2001 = 17.5%; 2002 = 13.6% and 2003 = 21.6%.

Domestic violence programs and providers served children who had been at a scene. About 1/5th of children were victims of abuse by the domestic violence perpetrator and 5-7% were victims of sexual abuse:

	1999	2000	2001	2002	2003
NM child served by domestic violence providers	3,313	5,710	4,199	5,418	5,757
% Child experienced child abuse by domestic violence perpetrator	22%	15%	20%	14%	22%
% Child experienced sexual abuse by domestic violence perpetrator	7%	4%	7%	5%	5%

Source: NM Interpersonal Violence Data Central Repository. Domestic Violence Trends in NM 2001-2003. NM Interpersonal Violence Data Central Repository. June 2004.

New Mexico PRAMS provides an additional estimate of women who were physically abused by a partner in the 12 months before pregnancy and during pregnancy. Because these are potential parents and then new parents, the data provide important insights into associated risks.

- ❖ Physical abuse by partner or husband in 12 months before pregnancy, 7.6% of women which translates to over 1,600 women for period 1998-2002;
- ❖ Physical abuse by partner or husband during pregnancy, 6.2% which translates to over 1,600 women;
- ❖ For abuse before or during pregnancy, women at greater risk had less than high school education (8.5% v 4.9% if had more than high school education), were single (8.2% vs 3.2% of married, were on public assistance (10% v 4.1% of those not on public assistance – data specific to 2001-2002);
- ❖ Native American women were at the twice risk; geographically they lived in the northwestern quadrant of the state; and
- ❖ Women who had at least one previous live birth were at greater risk in either period, suggesting there were children in the home who may have been exposed to the physical abuse events.
- ❖ Strategically, home visiting programs for higher risk women are evidence based for reducing child abuse & neglect, family violence and many more protective outcomes and need to be developed.

The NM Families FIRST perinatal case management program serves high risk mothers and could contribute significantly to reducing the risks of family violence. The program offers home visiting for assessment, however one of the MCOs serving the largest group has opted for case management by telephone. While deemed cost effective in the short run; costs associated with family violence in emergency room care will likely outstrip the shorter term savings of telephone case management. In the coming 5 year period, an evaluation of Families FIRST for short term outcomes is needed.

Children who are identified early, receive appropriate support and counseling, and experience cessation of violence in the home have better outcomes.

The focus for this state performance measure has been to improve data collection sources, and continue to implement policies and education that positively impact the overall incidence of domestic violence. There is currently much national debate about whether or not exposure to violence should be considered per se evidence of child abuse. The evidence is overwhelming that many children are adversely impacted, even if there is no evidence of physical or sexual abuse. The danger in making it a specific form of child abuse is that the adult victims will be penalized, Child Protection Services systems will be unable to cope with the numbers, and there will be more out of home placements of children, which have their own traumatic aspects. Continuing to NOT make it reportable means that many children will not be identified nor receive services. There is clear policy agreement that social services and domestic violence advocates need to cross train and

interact in a coordinated fashion, that victims need an array of resources to help them make safer choices and improve their parenting and deal with their substance abuse issues, and that perpetrators need to be held accountable for the family violence.

There are a number of initiatives that address the physical and psychological health and safety concerns for children in violent households. The negative effects of exposure to violence in the home can be balanced by esteem-building experiences and close, lasting relationships with caring adults. Safety planning for children not only helps them stay safe during an incident, but also empowers them to call 911, or ask other caring adults for help with the situation. Brief, school based, group and individual cognitive therapy approaches appear to be promising, especially in reducing symptoms of posttraumatic stress disorder (PTSD) among children exposed to violence. Home visiting for children age 0-3 years, promoting resiliency, and dealing more effectively with dating violence (before children enter the relationship) are all promising evidence based programs.

Family Violence, Prevention and Policy Work

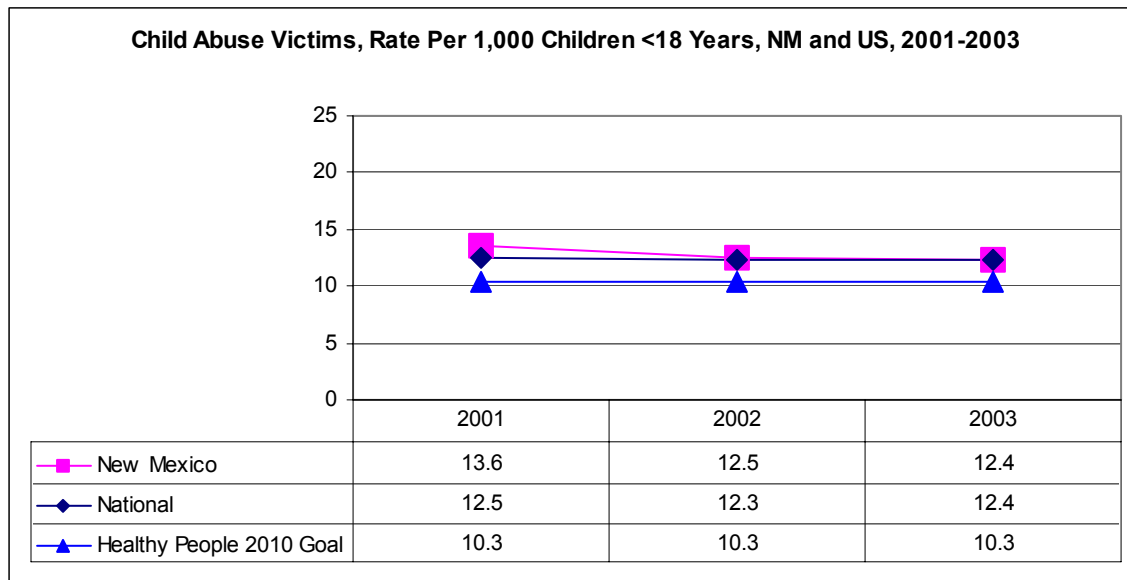
The FHB (with leadership from Victor La Cerva, the Title V MCH Medical Director) continues to distribute two of its award winning videos, Man to Man (for use in any context of working with young men) and Stolen Childhood (which educates about the adverse impact on children of exposure to domestic violence). Both are now being replicated in DVD format, along with their study guides. The Network Coalition is a collaborative effort with IPEMS, and a CDC funded grant to address both sexual and domestic violence, that continues to offer informational cross training sessions, legislative advocacy and the development of position papers with recommendations for action. In addition, there is a newly formed work group to address the issues of boys in the Santa Fe area, with statewide implications. The FHB program took an active role this last legislative session, analyzing many violence related bills, and the Medical Director, at the request of a Senator, wrote and got passed a memorial to assess the issue of children and domestic violence. The Medical Director, in his role as a Clinical Assistant Professor of Pediatrics, collaborates with a number of violence prevention related initiatives with UNM Medical school, and local Medical groups and Societies. These include lectures to medical students, Physician assistant, nursing and occupational students on issues of violence, including domestic violence,

firearms, and suicide. He is part of a working public health collaborative with the NM Medical Society, and maintains strong ties with the NM Pediatric Society, especially around legislative issues.

Data sources for section on Child witnessing violence: Incidence and Nature of Domestic Violence in NM Volumes I through IV. NM Interpersonal Violence Data Central Repository. Domestic Violence Trends in NM 2001-2003. NM Interpersonal Violence Data Central Repository. June 2004. Let Peace Begin With Us: The Problem of Violence in NM. Volume IV, May 2002.

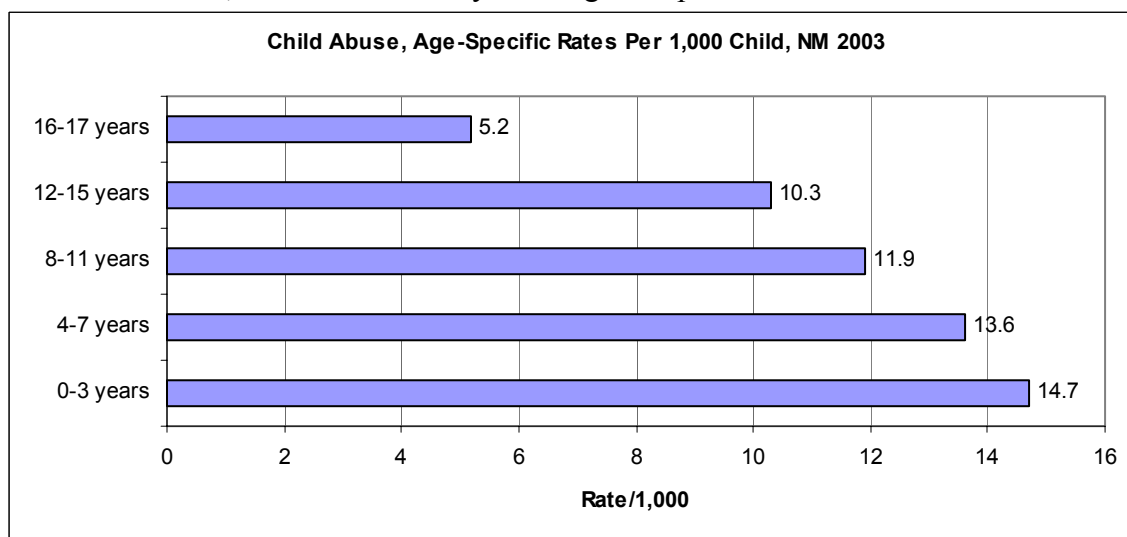
CHILD ABUSE AND NEGLECT

The Healthy People 2010 Goal is to reduce child maltreatment to less than 10.3 per 1,000 children <18 years of age, from the baseline of 12.9 in 1988. The NM Rates were very similar to US rates for period 2001-2003.



Source for all charts in this section: US DHHS, Administration on Children, Youth & Families, Child Maltreatment Reports for 2001, 2002 and 2003, Washington DC, US Govt. Printing Office. Data tables are available electronically at www.calib.com/nccanch; the report at www.acf.dhhs.gov/program/cb.

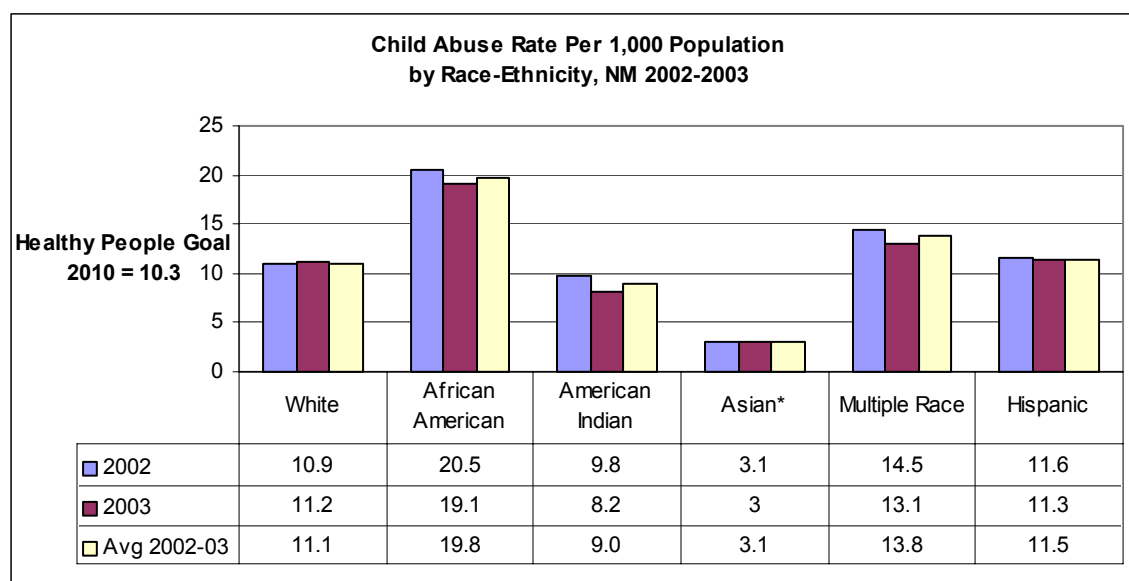
Younger children are at 2-3 times the risk of older children. The state CYFD program reported that in 2002-2003, infants under one year of age comprised 8-9% of the total victims.



Certain types of home visiting services have been shown to significantly reduce the risk of child abuse and neglect for young children age 0-3 years. This is especially true for families with social risk factors; yet very few new parents receive such services in NM. This age-set profile of

abuse has persisted over many years in the nation and the state. It under-scores the need for home visiting and parent support programs as a potential strategy to break the continued cycle as children move through older age sets. Prevention models for children >age 3 years need to be researched.

Child abuse rates by race ethnicity must be used with caution. American Indian children served by Tribal or BIA services are not included in the state report to the Agency for Children and Families; and are thus under-reported here. White children have a risk equal to Hispanic children; while African American children have twice the rate of these two groups. Multiple race children have 1.2 times the risk as White or Hispanic children.



*Includes Asian and Pacific Islander.

In NM as in the US, nearly 2/3 of cases are neglect; followed by nearly 1/3 physical abuse. Medical neglect comprised 2% in NM, sexual abuse ~5% and psychological maltreatment ~5%.

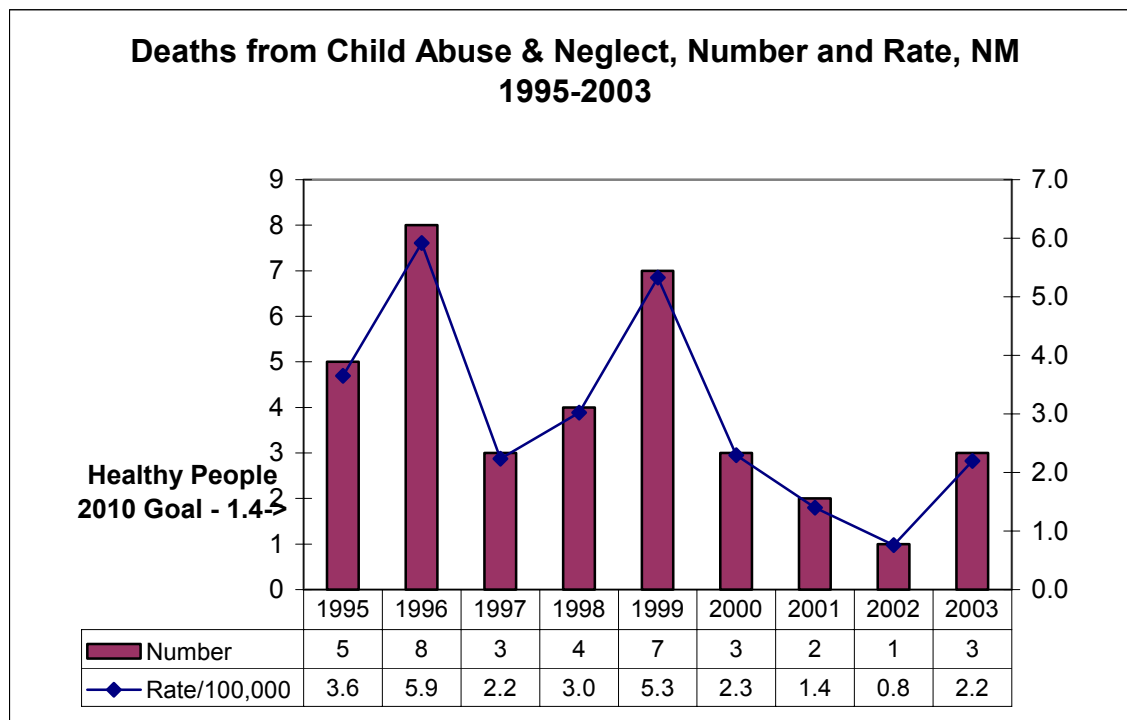
	NM Maltreatment, Numbers			Percent		
	2001	2002	2003	2001	2002	2003
PHYSICAL ABUSE	2,227	2,124	2,007	29%	30%	28%
NEGLECT	4,468	4,245	4,219	57%	59%	59%
MEDICAL NEGLECT	135	153	148	2%	2%	2%
SEXUAL ABUSE	459	382	384	6%	5%	5%
PSYCHOLOGICAL MALTREATMENT	481	245	341	6%	3%	5%
TOTAL	7,772	7,152	7,100			

Based on a national summary for 2003, the majority of perpetrators in abuse or neglect cases were parents, followed by relatives and unmarried partners of parents. Female perpetrators were the majority. Services included in-home and foster care.

FATAL CHILD ABUSE

In the period 1995 to 2003 there were 39 cases of fatal child abuse and/or neglect for ages 0-17 years reported by NM VRHS; all but 3 cases were among children age 0-4 years.

The number of fatal child abuse and neglect cases for the age group 0-4 ranged from 1-7 per year. The average number of cases was 4/ year and the average rate for period 1995-2003 was 2.96/100,000. This rate is twice the Healthy People goal of no more than 1.4 deaths/100,000.



The NM Child Fatality Review (CFR) process has examined fatal child abuse and neglect; findings will be forthcoming within the next two years (2006-07).

Two potential sources for information will be used in the coming grant period to further assess child abuse and neglect. The 2003 National Survey of Children's Health (NSCH) may provide critical information about factors associated with difficulties of parenting and the stresses of parenting in New Mexico in order to develop effective strategies for prevention of violence in the lives of children. Hospital discharges can be reviewed as well.

The quarterly and annual reports of NM Children Youth and Families Department do provide county based estimates and should be used to evaluate needs.

Qualities of Neighborhoods Where NM Children Live by Federal Poverty level, 2003

S10Q01: People in this neighborhood help each other out

FPL	Definite Agree	Some-what Agree	Some-what Disagree	Definite Disagree	Don't Know
<100%	27.7%	40.3%	12.9%	17.3%	2.0%
100 to <133%	30.6%	46.0%	13.0%	7.8%	2.6%
133 to <150%	19.1%	53.3%	9.2%	16.3%	2.2%
150 to <185%	30.0%	47.8%	11.8%	4.7%	5.7%
185 to <200%	27.9%	59.0%	5.4%	7.8%	0.0%
200 to <300%	34.4%	43.6%	11.2%	8.6%	2.3%
300 to <400%	36.5%	50.7%	6.6%	4.1%	2.1%
more%	41.1%	49.5%	4.9%	3.7%	0.9%
Total	32.2%	46.3%	10.0%	9.3%	2.2%

S10Q03: There are people I can count on in this neighborhood

FPL	Definite Agree	Some-what Agree	Some-what Disagree	Definite Disagree	Don't Know
<100%	42.5%	33.0%	5.2%	18.0%	1.3%
100 to <133%	49.5%	28.9%	9.7%	9.7%	2.2%
133 to <150%	52.3%	22.7%	12.5%	9.3%	3.3%
150 to <185%	55.5%	26.5%	6.6%	7.4%	4.1%
185 to <200%	51.4%	30.6%	11.5%	5.3%	1.2%
200 to <300%	59.5%	27.1%	5.9%	6.3%	1.1%
300 to <400%	65.6%	23.0%	3.7%	5.3%	2.5%
400% or more%	68.7%	20.8%	5.0%	3.9%	1.6%
Total	55.3%	27.2%	6.4%	9.3%	1.9%

S10Q94: There are people in this neighborhood who might be bad influence on my child

FPL	Definite Agree	Some-what Agree	Some-what Disagree	Definite Disagree	Don't Know
<100%	30.1%	20.1%	16.3%	31.3%	2.3%
100 to <133%	30.8%	20.1%	14.9%	28.4%	5.5%
133 to <150%	23.8%	27.0%	25.3%	21.7%	2.2%
150 to <185%	24.1%	22.9%	25.3%	23.4%	4.4%
185 to <200%	21.0%	38.2%	24.2%	16.2%	0.5%
200 to <300%	30.9%	23.1%	16.1%	27.6%	2.3%
300 to <400%	18.2%	24.0%	14.6%	37.0%	6.2%
400% or more%	14.5%	21.4%	21.6%	37.3%	5.1%
Total	25.2%	22.7%	18.4%	30.1%	3.6%

S10Q02: we watch out for each other's children

FPL	Definite Agree	Some-what Agree	Some-what Disagree	Definite Disagree	Don't Know
<100%	41.9%	34.7%	7.6%	14.2%	1.5%
100 to <133%	53.7%	25.6%	6.5%	9.2%	5.0%
133 to <150%	35.8%	41.0%	6.8%	15.0%	1.4%
150 to <185%	51.4%	32.4%	6.3%	5.8%	4.0%
185 to <200%	37.7%	46.5%	7.5%	6.6%	1.8%
200 to <300%	49.8%	36.3%	5.8%	5.8%	2.0%
300 to <400%	55.3%	30.9%	6.9%	4.5%	2.5%
more%	52.8%	33.2%	6.4%	5.4%	2.3%
Total	48.3%	34.0%	6.7%	8.5%	2.5%

S10Q05: If child were outside playing and got hurt or scared, there are adults nearby who I trust to help my child

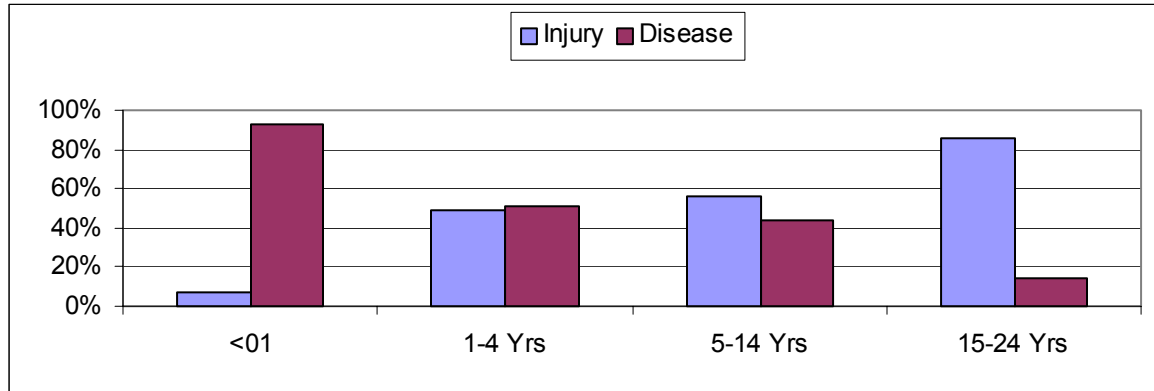
FPL	Definite Agree	Some-what Agree	Some-what Disagree	Definite Disagree	Don't Know
<100%	52.5%	27.1%	7.0%	10.2%	3.2%
100 to <133%	55.5%	24.5%	5.4%	13.2%	1.5%
133 to <150%	55.1%	31.1%	5.1%	8.7%	0.0%
150 to <185%	67.1%	20.4%	3.2%	3.6%	5.7%
185 to <200%	55.1%	31.2%	9.9%	3.8%	0.0%
200 to <300%	63.8%	25.9%	5.4%	3.8%	1.0%
300 to <400%	73.1%	16.3%	3.8%	2.5%	4.3%
400% or more%	68.8%	21.6%	4.1%	3.7%	1.8%
Total	61.4%	24.3%	5.4%	6.5%	2.4%

The data in these 5 tables are important for developing strategies to improve the sense of safety and wellbeing of NM children and will be useful for interpreting Outcome 4, **NM children and youth will be safe and supported in communities**, in "Growing Our Future, Together, 2005 Childrn's Report Card, of the NM Children's Cabinet. The 5 tables are from the NSCH; weighted estimates from analysis done in Stata Version 7.

NON-FATAL AND FATAL INJURIES IN THE MCH POPULATION

Injuries are the leading cause of death and hospitalization in young children and youth. Twice as many young children and youth age 1-24 years died from injury than from all diseases combined.

Injury and Disease Deaths by Age Group, NM 2002



From Injuries in New Mexico: Successes & Challenges Jan 2002 VRHS data pg 3,
www.health.state.nm.us

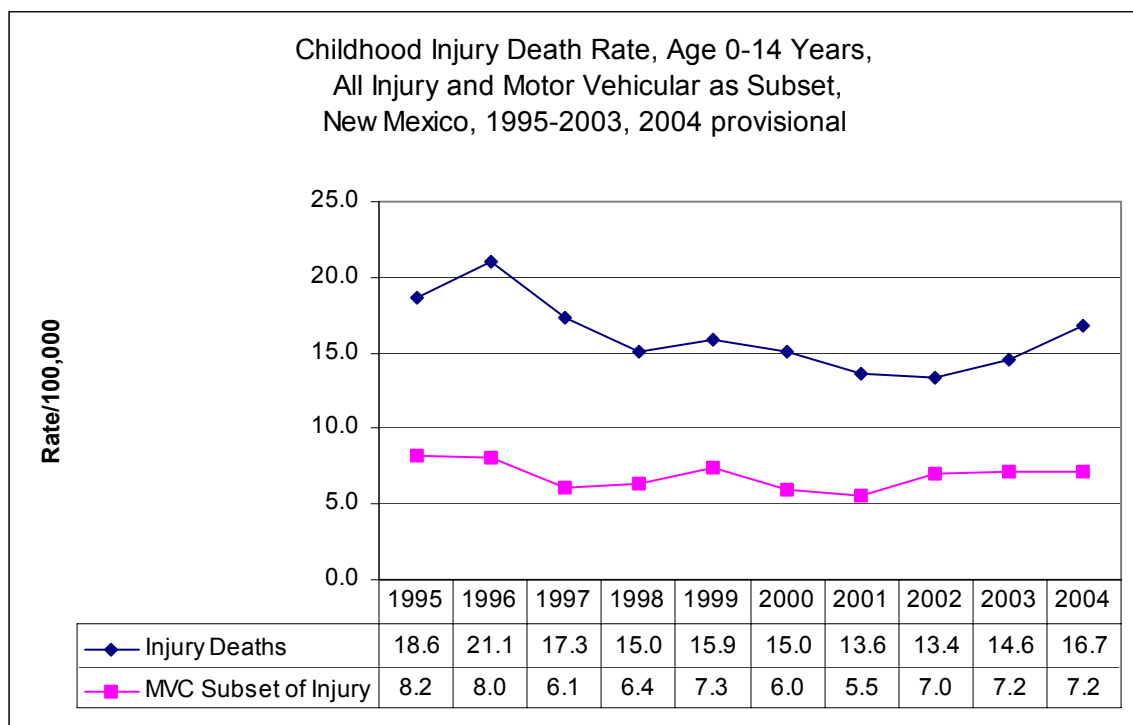
After surviving the first year of life, unintentional injury is the cause of almost half of all deaths in young children and youth age 1-24 years

LEADING CAUSES OF INJURY DEATH DIFFERED BY AGE GROUP, NM TOTAL 1999-2002:

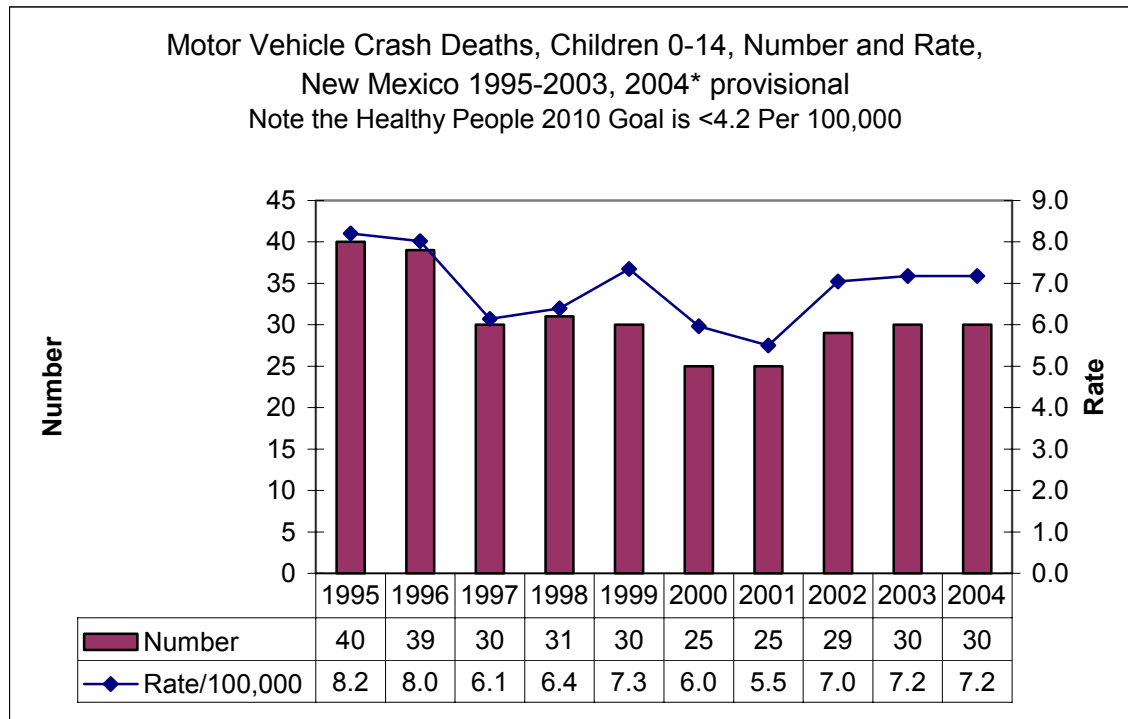
0-4 years Motor vehicle crash, 30 deaths, 27% Suffocation, 20 deaths, 18% Poisoning, 6 deaths, 5.4% Drowning, 9 deaths, 8.1% Pedestrian, 3 deaths, 2.7% Other, 43 deaths, 38.7% Other: includes cut/pierce, fall, fire/burn, firearm, natural-environmental	5-9 years Motor vehicle crash, 27 deaths, 56.3% Drowning, 3 deaths, 6.3% Natural, environmental, 3 deaths, 6.3% Firearm, 2 deaths, 4.2% Other, 13 deaths, 27.1% Environmental includes excessive heat & cold, animal bites, storm damage, etc. Other includes fall, fire/burn, other land transport, struck by/against, etc
10-14 years Motor vehicle crash, 47 deaths, 54% Firearm, 14 deaths, 16.1% Suffocation, 10 deaths, 11.5% Other land transport, 8 deaths, 9.2% Poisoning, 3 deaths, 3.4% Other, 3 deaths, 5.7% Other includes drowning, pedestrian, etc	15-24 years Motor vehicle crash, 413 deaths, 41.9% Firearm, 275 deaths, 27.9% Poisoning, 86 deaths, 8.7% Suffocation, 73 deaths, 7.4% Cut/Pierce, 23 deaths, 2.3% Other, 116 deaths, 11.8% Poisonings are primarily drug overdose deaths Other includes fall, drown, fire/burn, machinery, other land transport, pedestrian, etc

The previous table was adapted from Injury Hurts New Mexico February 2005, NM VRHS data page 12, www.health.state.nm.us

Injury prevention for children age 0-4 requires strategies to educate parents and others who care for young children. Once again, home visiting for parents of 0-3 year old children is a critical need. There is no substitute for a home visit that includes an injury prevention “safety check” that covers many forms of injury. Like defensive driving courses for state employees, a safety check can have an impact for parents for many years – leading to safer homes for children. The “teachable moment” as well as venue for injury prevention for children age 5 and older is greatly expanded beyond the home. While adults continue to be responsible for supervision of children – guardians for their safety – young children can learn basics of safety in day care and school, and other places where children gather. The nature of risks change as children grow older, and fatal injury among males is higher than for females. The injury mortality rate among the age group 0-14 is comprised of all types of fatal injury as enumerated in the tables on the preceding page. Numbers ranged from 60-80 each year in the past ten years; motor vehicle crash injury made up 40-50% of injury deaths in past 10 years in NM



National Performance Measure 10: The rate of deaths to children 0-14 caused by motor vehicle crashes per 100,000 children.



Motor vehicle crashes comprise the majority of injury in this age group. Fatal motor-vehicle crash injuries are the tip of the iceberg when data regarding all injuries, serious injuries and fatal injuries are examined. Using 2002 data from the NM Traffic Safety Bureau report for children in this age group:

- 2,501 motor-vehicle crash injuries
- 29 fatal motor-vehicle crash fatalities
- 974 serious motor-vehicle crash injuries (incapacitating or visible but not incapacitating on the traffic crash report)
- 1498 other motor-vehicle crash injuries (not serious, not fatal)

In 2002

- There were 90 drivers under the age of 15 who were injured in crashes, five involved alcohol
- Data by child deaths by county and specific “at risk” roads can be used to design specific prevention strategies at the community level

Risk reduction and prevention issues identified by the Transportation Panel of the NM Child Fatality Review included

- Lack of use of car seat or other appropriate restraint
- Alcohol involved crashes in which children perished
- Driver’s high rate of speed at the time of the crash

- Young driver's inexperience related to many factors such as the vehicle type, traffic conditions at the time, road conditions at the time, distractions from other passengers or use of telephones
- Children riding in the bed of a pick-up truck

Statewide and local initiatives to reduce non-fatal or fatal injuries include

- Promotion of practices mandated in the NM Child Restraint Law
- Practices mandated in the new "all positions seat belt law"
- Find ways to fund car seats for all NM infants and young children
- Assure that car seats for infants and children are installed correctly for car seat and vehicle type
- Efforts to expand the network of Safe Kids chapters and support the statewide coalition, including Safer NM Now
- Enforcement of driving while intoxicated (DWI) laws

Intentional injuries are primarily homicide in this age group; child abuse comprises the majority and most are under age 5 (see chapter on children and violence).

2002, Traffic Safety Data on Motor Vehicle Crash Injuries:

Traffic Safety Data, 2002 only	All Injury	Serious Injury	Fatalities	Pedestrian Death	Pedestrian Injury
Under 5	490	203	7	0	11
5-9 Years	863	335	9	2	21
10-14 Years	1148	436	13	0	38
Total	2501	974	29	2	70

2002, Traffic Safety Motor Vehicle Crash Injury Rates, Children 0-14

Rate by Age	All Injury	Serious Injury	Fatalities	Pedestrian Death	Pedestrian Injury
Under 5 years rate	363.0	150.4	5.2	0.0	8.1
5-9 years rate	632.9	245.7	6.6	1.5	15.4
10-14 years rate	771.9	293.2	8.7	0.0	25.5
Age 0-14 rate	607.7	236.7	7.0	0.5	17.0

1999-2002, Traffic Safety Motor Vehicle Crash Injury Rates, Children 0-14

Traffic Safety Injury Report	1999	2000	2001	2002	2003
Age 0-14 Non-fatal Injury Rate/100,000 Population	723.9	632.3	600	607.7	Not Avail

Fatal and Non-Fatal Injury in Youth Age 15-24: The rate of all non-fatal injuries among children 15-24 in 2000 was 3068. This rate was above Healthy People 2010 that has a goal of not more than 933 non-fatal injuries per 100,000. The baseline was 3,116 non-

fatal injuries per 100,000 persons, ages 16-20, and 2,496 non-fatal injuries per 100,000 for persons ages 21-24 in 1997.

- Data on non-fatal injury was in development at the time of this report.
- More females were injured in Motor Vehicle Crashes (MVCs) than males and the number of injuries increases at age 15.¹
- Non-fatal, unintentional injuries account for 84% of injury-related hospitalizations in this age group
- Risk factors included: lack of helmet laws for bicycles (all ages) and on motorcycles (over 18 years of age), use of alcohol, drugs or tobacco, few Developmental Assets, poverty, and lack of health insurance.
- New Mexico has the 6th highest seatbelt use in the United States for 2003. In 2003 the Youth Risk and Resiliency Survey reported that 88.5% of high school students reported using seat belts.² The state continues to add new School Based Health Centers. Injury is the leading cause of death in the age group 15-24.
- The rate of all youth deaths ages 15-24 in 2002 was 106.5/100,000³
- The death rate was at a high of 131 in 1996 and a low of 90.0 in 2001 with an average death rate over 8 years of 112.65/100,000
- The leading causes of death for youth ages 15-24 were: unintentional accidents (including MVC) assault (homicide) and intentional self harm (suicide), malignant neoplasms, influenza and pneumonia.⁴

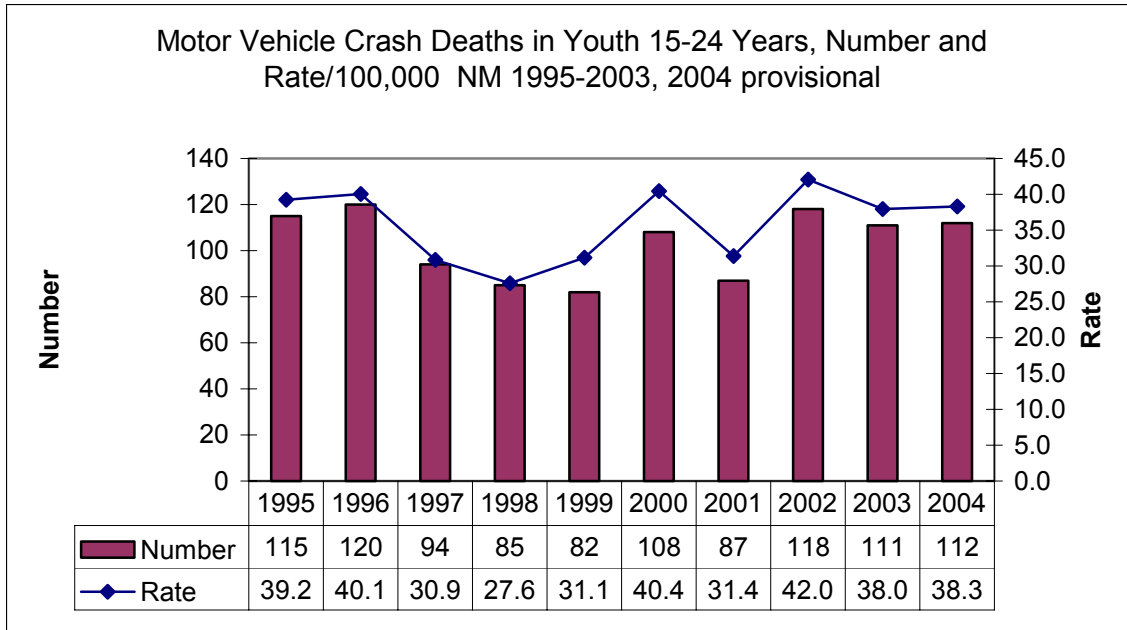
Motor vehicular crashes in this age group ranged from 80-115 per year; the overall rate for the period has not changed. Fatalities in this group are associated with many factors that were cited above.

¹ New Mexico Teenagers in Crashes, 1999-2002, Produced for the New Mexico Traffic Safety Bureau

² New Mexico Youth Risk and Resiliency Survey (YRRS), 2003 Report of State Results

³ New Mexico Selected Health Statistics Annual Report, Table 3.12 Ages 15-24 Age-Specific Death Rates Leading Causes by Race/Ethnicity New Mexico Residents 2000-2002 Average

⁴ Bureau of New Mexico Vital Records and Health Statistics, 2003 Preliminary Data



Additional information about injury in NM is found at www.health.state.nm.us. Key reports are from the injury prevention program and the YRRS. The annual reports of the Office of Medical Investigator (OMI) at the UNM; and the Traffic Safety Bureau of NM Transportation Department are key to assessing risk factors.

HEALTH OF NEW MEXICO YOUTH

Youth Development and State Performance Measure 1: The number of counties and tribal entities implementing positive youth development strategies defined by 6 key criteria.

Among County Health Improvement Councils (CHICs), the five key criteria for implementing positive youth development.

- ❖ 1-CHIC has identified positive youth development as a priority in its annual plan;
- ❖ 2-CHIC membership includes at least two youth each year;
- ❖ 3-CHIC has at least one person trained in positive youth development;
- ❖ 4-CHIC has a plan for at least one evidence-based intervention in the annual plan;
- ❖ 5- CHIC plan for youth involved youth and approved by youth;
- ❖ 6-CHIC coordinates efforts with School Health Advisory Committee (SHAC).

Healthy People 2010 Goals: The National Initiative to Improve Adolescent Health by the Year 2010 (NIIAH 2010) has identified 21 Critical Objectives for adolescent health and defines adolescent health broadly, complementing the traditional focus on categorical health problems and antecedents by concepts of healthy adolescent development and health-promoting environments to provide a proactive foundation for promoting the health and safety of adolescents and young adults. The NIIAH's goal is to foster cooperation among different partners, including states; its framework seeks new approaches, work with a variety of partners, and the concept of adolescent health from an action-oriented perspective.

The National Initiative is based on a comprehensive approach that recognizes that seemingly isolated adolescent problems are influenced by common antecedent factors – those that protect and those that can jeopardize health and safety. Youth opportunities and supports are increasingly important in a world of rapidly changing labor markets, rationales for civic engagement, and a growing need to communicate and cooperate across age, ethnic, religious, cultural, and gender boundaries. Youth who spend time in communities that are rich in developmental opportunities for them experience less risk and show evidence of higher rates of positive development. Diverse program opportunities are more likely to support broad adolescent development and attract the interest of and meet the needs of a greater number of youth. Cultural groups vary in what characteristics they most value for their youth and adults. Core human needs that researchers agree are universal include the need to feel competent, to be socially connected, to feel valued and respected, to actually be making a difference in one's social group, to feel that one has some control over one's own behaviors and experiences, and to

have one's physical, emotional and spiritual needs met.

Relying on theory, practical wisdom and empirical research, youth development advocates and researchers agree upon personal and social assets that can be viewed both as universals and broken down into subcomponents that reflect cultural specificity. These assets include: caring and compassion; character; competence in academic, social, and vocational arenas; confidence; and connection. Researchers and advocates have also come to some consensus regarding features of positive developmental settings. They include: physical and psychological safety; appropriate structure; supportive relationships; opportunities to belong; positive social norms; support for efficacy and mattering; opportunities for skill building; and integration of family, school, and community efforts. These features moderate or mediate the effects of individual vulnerabilities or environmental hazards, and diminish the likelihood of negative health and social outcomes.

Through the Youth Risk Resiliency Survey (YRRS), New Mexico monitors this strategy because the evidence shows when youth are supported and feel connected they are less likely to take risks that may have life-long consequences. Researchers on resiliency and protective factors have learned that a significant percentage of those adolescents who appear to have the worst of all possible environmental conditions against them are able to overcome these adversities if they have a sufficient level of resiliency and protective factors working in their favor. Their conclusion is that it is not so much the risk factors that predict the future life prospects of adolescents but whether there are sufficient resiliency and protective factors in their lives.*

The following pages show two sets of resiliency factors, in three different contexts:

► Positive Support

Parent and Family
School
Community

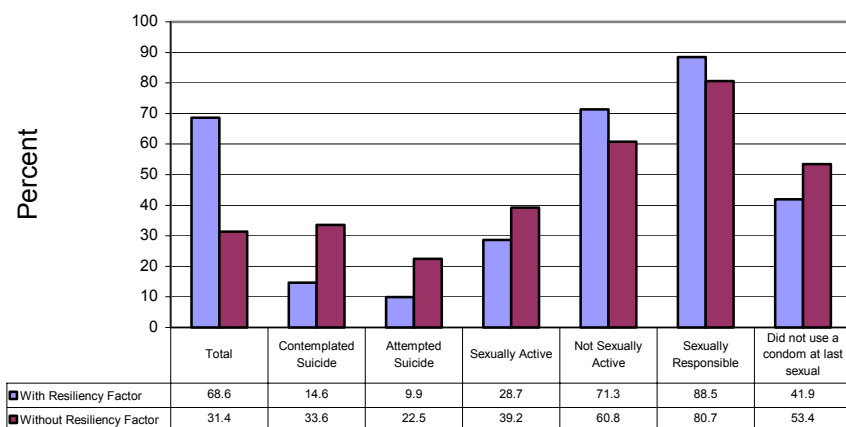
► Boundaries and Expectations

Parent and Family
School
Community

Not each and every resiliency factor is protective against a specific risk, and some risks have other factors not found in the YRRS. The set of three graphs show that teens who have less support take more risks; and that teens with more support take fewer risks. This model appears relevant to all but sexual behavior which is, in one perspective, not a dangerous health risk but part of normal development. Research from the National Longitudinal Adolescent Health Survey has shown that other factors are more powerful regarding youth, their sexual development and sexual behaviors.

A caring and supportive relationship with a parent or adult in the family can reduce serious risk taking behaviors. In 2003, 68.6% ($\pm 2.4\%$) of NM youth reported that they had such a relationship. An estimated 31.4% ($\pm 2.3\%$) did not.

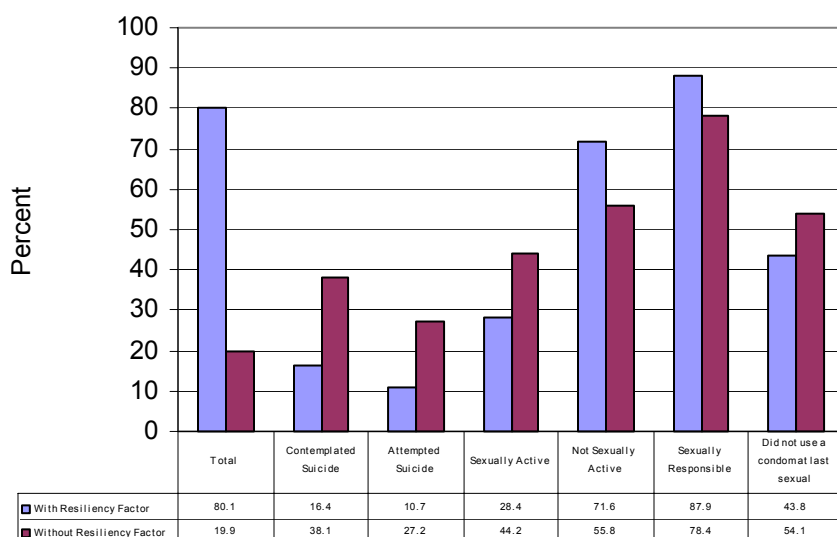
Resiliency Factors and Risk Behaviors Caring and Supportive Relationships in the Family, Grades 9 - 11, YRRS, 2003



Data Source: Youth Risk and Resilience Survey

Although parents and other adults may tire of setting boundaries and expectations when their teen children seem to ignore them or pronounce it “boring”, it does have importance to their teens. It helps them to resist serious risk taking.

Resiliency Factors and Risk Behaviors Boundaries and Expectations in the Family, Grades 9 - 11, YRRS, 2003

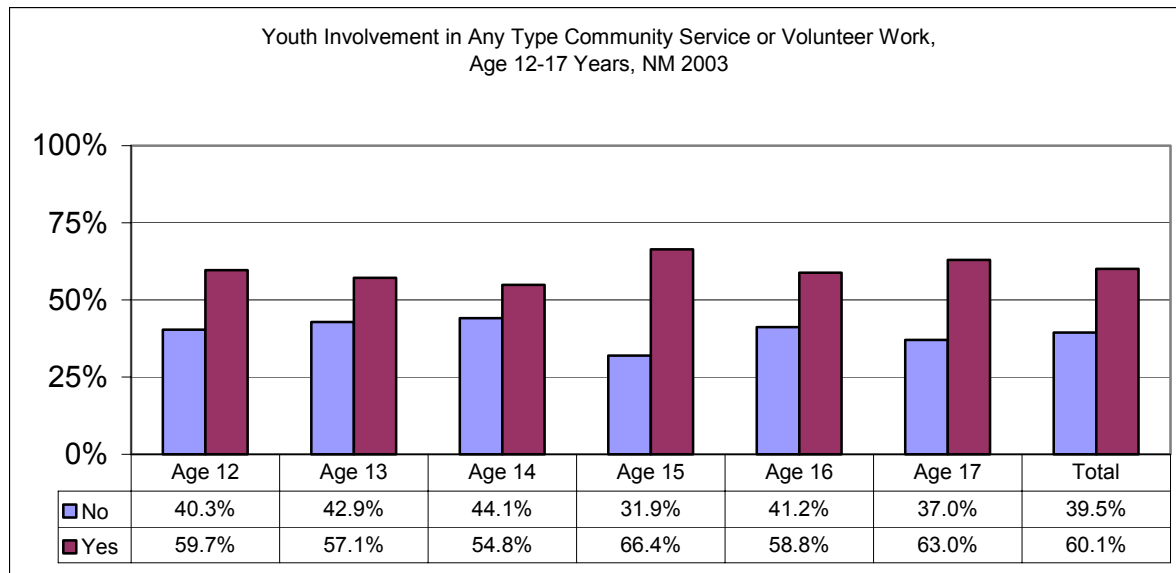


Data Source: Youth Risk and Resilience Survey

An estimated 80.1% ($\pm 1.8\%$) of NM youth reported there were boundaries or expectations in the family. The next graph shows how such expectations protect youth.

Beyond the family, the school and the community environments have great potential to support youth in their own resolve to take fewer risks.

Finally, research has shown that youth involvement in different kinds of activities – beyond the classroom – are associated with lower prevalence of serious risk taking. The NSCH provides many examples; one is shown here.



Data Source: Centers for Disease Control & Prevention, National Center for Health Statistics, State & Local Area Integrated Telephone Survey, National Survey of Children's Health, 2003. Analysis by NM MCH Epidemiology

References: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Adolescent and School Health; Health Resources and Services Administration, Maternal Child Health Bureau, Office of Adolescent Health; National Adolescent Health Information Center, University of California, San Francisco. *Executive Summary – Improving the Health of Adolescents & Young Adults: A Guide for States and Communities*. Atlanta, GA: 2004. National Research Council and Institute of Medicine (200) Community Programs to Promote Youth Development. Committee on Community-Level Programs for Youth. Jacquelynne Eccles and Jennifer A. Gootman, eds. Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education. Washington, DC: National Academy Press.

HEALTH OF NEW MEXICO CHILDREN: HEALTHYWEIGHT, OVER WEIGHT & OBESITY

State Performance Measure _ The percent of adolescents who are overweight or at risk of overweight (BMI) \geq 85th percentile for age and gender.

Healthy People 2010 Goal 19-3 is to reduce the proportion of children and adolescents who are overweight or obese to 5% from the 1988-94 baselines of 11%.

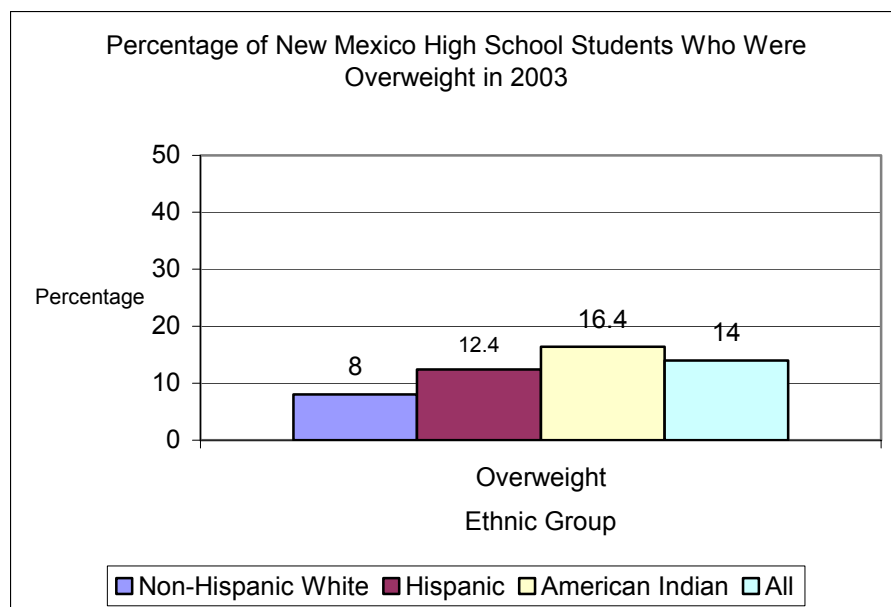
The prevalence of overweight and obesity in children is rising. Childhood obesity is associated with adverse medical and psychosocial consequences. Overweight acquired during childhood or adolescence may persist in adulthood with increased risks of some chronic disease later in life. As a result, the rising prevalence of obesity and chronic disease will place more burdens on the health care system, including increased costs of medical care.

Childhood obesity is associated with adverse medical and psychosocial consequences. Overweight acquired during childhood or adolescence may persist into adulthood with increased risks of some chronic disease later in life. As a result, the rising prevalence of obesity and chronic disease will place more burdens on the health care system, including increased costs of medical care.

Following the published data from the CDC's Third National Health and Nutrition Examination Survey (NHANES III), concern has been expressed that the prevalence of obesity in children and adolescents may be increasing in New Mexico, but definitive data are lacking. Therefore, Title V leadership is committed to establishing a baseline to assess the extent of obesity on childhood in New Mexico and develop a plan of action for its prevention.

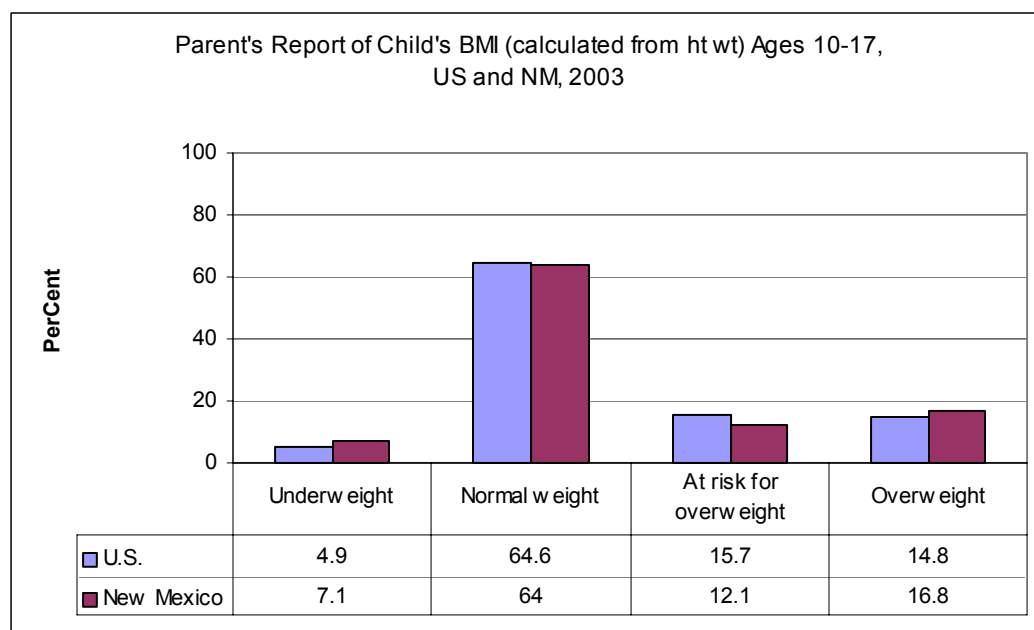
In 2003, 57% of New Mexico adults were overweight or obese. (CDC BRFSS, 2003), And 24% of New Mexico high school students were overweight or at risk for overweight. (NM Youth Risk & Resiliency Survey, 2003). In some counties, 36% of 9th - 12th graders were overweight or at risk of becoming overweight.

In 2003, youth at risk of being overweight or those who were overweight worked hard at this problem:



>70% exercised to loose weight in past 30 days
 >50% ate les food, fewer calories or low fat foods to loose weight or keep from gaining weight
 15% of overweight boys and 21% of overweight girls vomited or took laxatives, twice the percentage of normal weight youth.

Data Source: CDC/NCHS/SLAITS/National Survey Children's Health, 2003. Analysis by NM MCH Epidemiology



While there are limitations to self-reported BMI data, it is interesting to note that the self-report for NM high school students was 14%; and as

seen in the next table, the parent's report of their children being over-weight was 16.8% - the latter actually very close to the 14% of the YRRS.

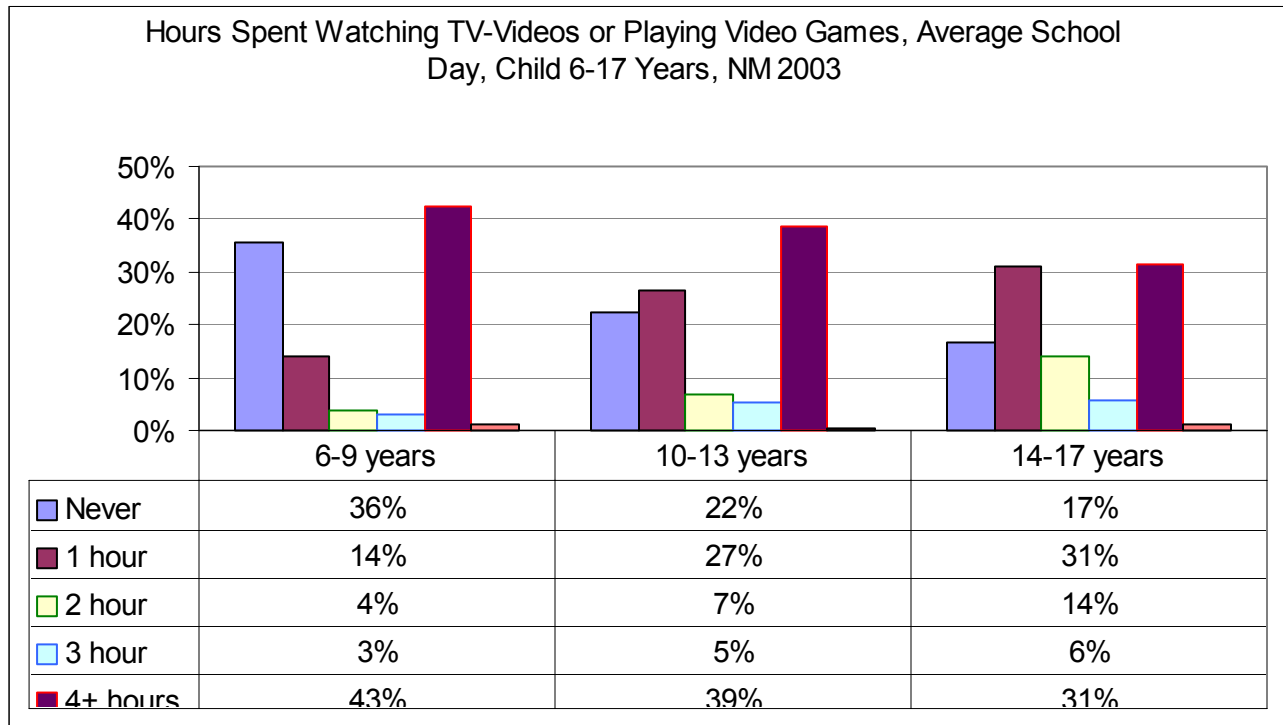
Body weight status based body mass index (BMI) as reported by parent, children and youth ages 10-17 years, Nationwide and New Mexico, National Survey of Children's

The 2003 NSCH also found that parents of NM children reported being concerned a little or a lot for their children about eating disorders:

- ❖ 24% of parents of children 6-9 years
- ❖ 29% of parents of children 10-13 years
- ❖ 28% of youth age 14-17 years

Over the last twenty years, much has been done to develop information with regard to the effects of television viewing on consumers and their food behavior. The chart above depicts the number of hours New Mexican children spent watching TV-Videos or Playing Video games, during an average school day. Investigators hypothesize that television viewing causes obesity by one or more of three mechanisms: (1) displacement of physical activity, (2) increased calorie consumption while watching or caused by the effects of advertising, and (3) reduced resting metabolism. The relationship between television viewing and obesity has been examined in a relatively large number of cross-sectional epidemiologic studies but few longitudinal studies. Many of these studies have found relatively weak, positive associations, but others have found no associations or mixed results; however, the weak and variable associations found in these studies may be the result of limitations in measurement. Several experimental studies of reducing television viewing recently have been completed. Most of these studies have not tested directly the effects of reducing television viewing behaviors alone, but their results support the suggestion that reducing television viewing may help to reduce the risk for obesity or help promote weight loss in obese children. One school-based, experimental study was designed specifically to test directly the causal relationship between television viewing behaviors and body fatness. The results of this trial provide evidence that television viewing is a cause of increased body fatness and that reducing television viewing is a promising strategy for preventing childhood obesity. Statistics from all studies dealing with trends in television viewing indicate that across the population and particularly during childhood, television exposure time is increasing. In 1964, only 8 percent of households in the U.S. received nine or more channels, 1983, 61 percent received that number. Cable channels, available today, have added hundreds to the number of channels available. Recent Kaiser Family Foundation studies show that children ages 8 to 18 watch about three hours of television per day, while younger children, from infants to 6 years old, are watching about one

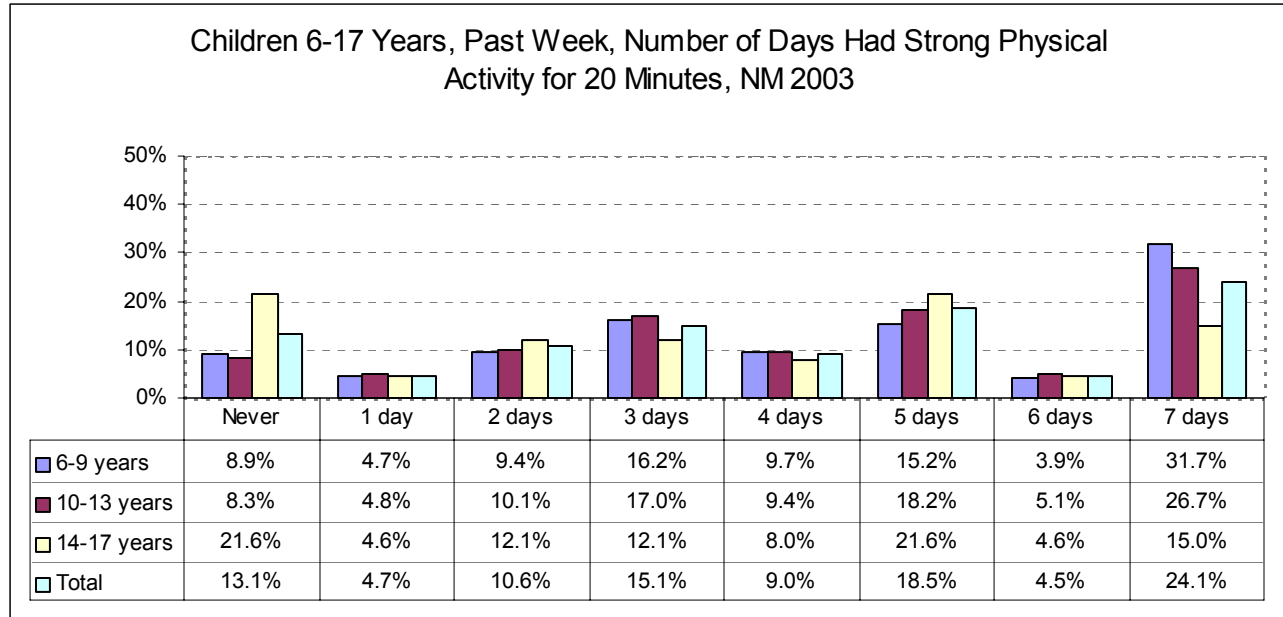
hour per day, on average. Studies on the effects of television exposure time on children indicate that in addition to influencing weight status directly through physical inactivity and increased food consumption, the effects of body fatness may occur indirectly over both short and long periods. (Federal Trade Commission, 1978). They found no significant viewing differences between obese, super-obese, and non-obese children with respect to size of peer group, ability to cooperate with friends, time spent alone, or time spent in other leisure activities (Dietz and Gortmaker 1985).



Data Source: Centers for Disease Control & Prevention, National Center for Health Statistics, State & Local Area Integrated Telephone Survey, National Survey of Children's Health, 2003. Analysis by NMMCH Epidemiology

New Mexico data, above, indicate that a higher percentage of children ages 6-9 years old, watch 4+ hours of TV per day, than the percentage watching 4+ hours who are 10-17 years old . The same is true for those who never watch TV, a larger percentage of 6-8 year old New Mexicans reported never watching TV, as compared to children ages 10-17. Thus, while the tendency to never watch TV decreases with age, the tendency to watch 4 or more hours of TV per day also decreases with age. The tendency to watch 1-3 hours per day increases with age in New Mexico.

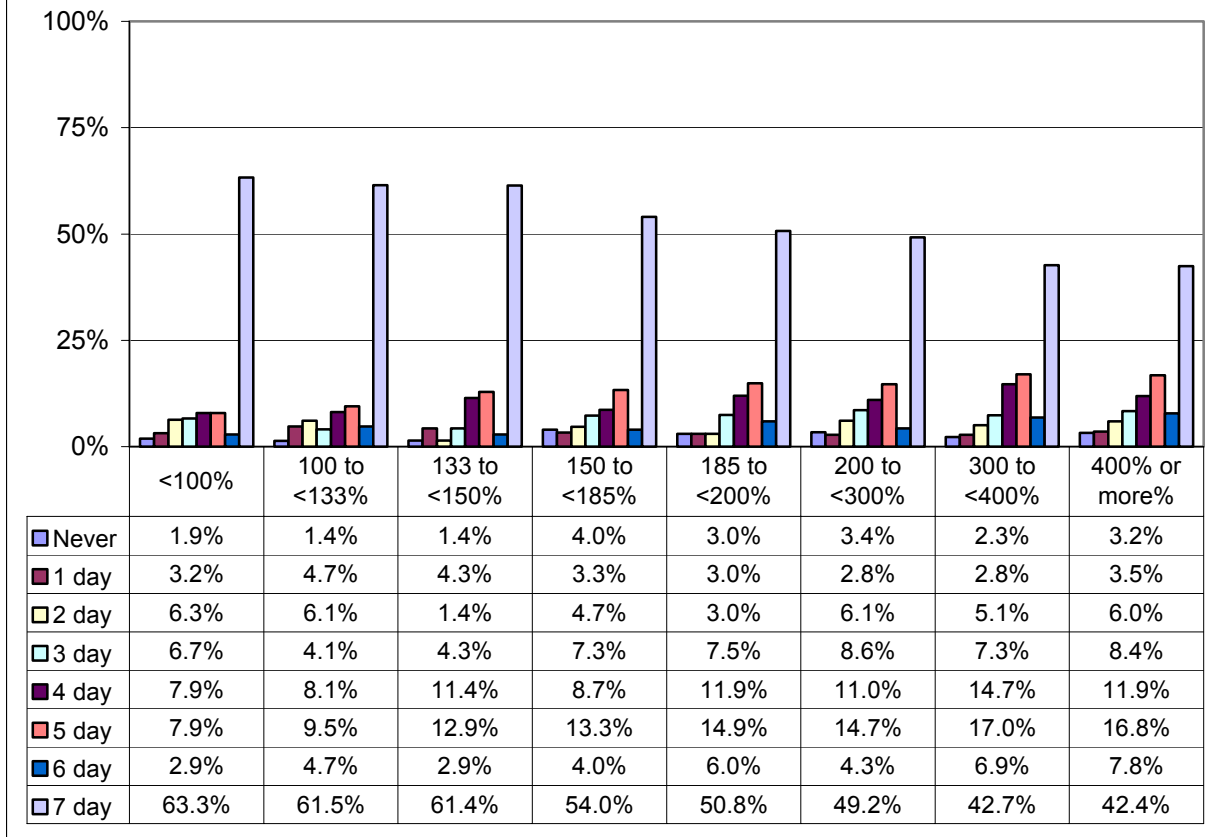
The state's 6-9 year olds were more inclined to take part in strong physical activity for 20 minutes a day, 7 days per week than are 10-13 or 12-17 year olds. The least likely to do this are the 14-17 year olds.



Data Source: CDC/NCHS/SLAITS/National Survey Children's Health, 2003. Analysis by NM MCH Epidemiology

The NCHS survey also indicates that in New Mexico, only 54.9% of New Mexican families report eating a meal together 7 days per week. An estimated 34.6% eat 3 to 6 meals together per week, and 7.7 percent of families surveyed only a meal together 1 to 2 times a week, and the families who never eat together totaled 2.6 percent. The WIC Program is recommending that families try to eat at least one meal together everyday.

Number of Days/Week NM Families with Children <18 Years
Ate A Meal All Together
by Federal Poverty Level of Household, NM 2003



Data Source: CDC/NCHS/SLAITS/National Survey Children's Health, 2003. Analysis by NM MCH Epidemiology

Approximately 16.8% of New Mexican families over 400% of poverty eat together 5 days a week as compared to 7.9% of families whose income is less than 100% of the federal poverty level. This is often due to the latter having to work several jobs to make ends meet. However, it is interesting to note that 63.3% of families less than the federal poverty level eat together 7 days per week as compared to only 42.2% of families living at 400% of federal poverty level.

In 2002, CDC documented that 22% of low-income children between 2-5 years of age who participated in federally-funded nutrition programs were overweight or at risk for overweight

(CDC Pediatric Nutrition Surveillance System, 2002) A poor home situation has been associated with a nine-fold increased risk of obesity in kids who were neglected and 2-3 times increased risk for kids in poor living conditions. The concern has been expressed that the prevalence of obesity in children and adolescents may be increasing in New Mexico, but definitive trend data are lacking.

National data shows that among adults the trend for a BMI>30 went from 12% in 1991 to 17.9% in 1998. No differences were seen by gender, age, race, smoking status, or education levels and an increase was seen in all states. .

There was a 39% increase in obesity among 12-17 year olds in the U.S. from 1970 compared with 1980 data. Increases were seen in all ages, both sexes. Comparing Skin Fold measurements from 1965 to 1980 there was a 54% increase in overweight among 6-11 year olds and a 98% increase in prevalence of obesity. CDC NHANES III. Twenty three percent (23%) of 9-12th graders had a higher than normal BMI (includes overweight and at risk of overweight, all those with BMI \geq 85th percentile for age and gender.

(YRRS)

Disparities: Children with obese mothers, low family incomes, and lower cognitive stimulation have a significantly elevated risk of becoming obese, independent of other demographic and socioeconomic factors. In contrast, increased rates of obesity in black children, children with lower family education, and nonprofessional parents may be mediated through the confounding effects of low income and lower levels of cognitive stimulation

Strauss and Knight investigated the association between the home environment and socioeconomic factors and the development of obesity in children. Maternal obesity was the most significant predictor of childhood obesity (OR: 3.62 [2.65-4.96]). The cognitive scores and household income were also significant predictors of childhood obesity; low income: 2.91 [1.66-5.08], medium income: 2.04 [1.21-3.44]). Children who lived with single mothers were also significantly more likely to become obese, as were black children, children with nonworking parents, children with nonprofessional parents, and children whose mothers did not complete high school. Neither the child's gender nor emotional scores contributed to the development of obesity. After controlling for the child's initial weight-for-height, maternal body mass index, race, marital status, occupation, education, and emotional scores, only the cognitive score and family income

remained significant predictors of childhood obesity. Richard S. Strauss* and Judith Knight, The National Longitudinal Survey of Youth

The percentage of obese New Mexico Native American high schools students (16.4%) and Hispanic high school students (12.4) is much higher than Non Hispanic White students (8%).

Risk Factors for obesity or over weight are related to increased caloric intake, decreased physical activity, mother's weight, cognitive scores, and household income, single head of household, length of exposure to food, availability of food, restrained feeding, reactive overeating, modeling of behaviors, prompting by parents and child care providers, culture, peer influences, and media influences. Developmentally, the ages of infancy, 5 and 7 years of age, and teens are when children naturally add body fat.

Impact The impact of obesity on children can be hypertension (9 times greater in prevalence) and Diabetes. Other problems kids may have are fatty liver and gallstones, which are usually rare in children, but more common among obese kids. Obese children may also present with lowered immune function, higher rates of bronchitis, upper respiratory infections, skin alterations, more acne, head aches, and orthopedic problems.

Positive Influence Factors Education, physical activity, healthy feeding relationships, and a stable home life are positive influences, decreasing the prevalence of obesity.

State Targets: Although no state target exists today, Family Health Bureau would target no greater than 15% would be overweight (85%tile) and no greater than 5% would be obese.

Evidence based policies: New Mexico just legislated that the Public Education Department regulate Competitive Foods in public schools. The New Mexico legislature has also passed some bills recently related to Physical Education mandatory as part of overall curriculum for some age groups. Evidence based programs are increased physical activity, decreased energy intake, and guiding principles related to sharing the power within the feeding relationship for infants and children.

Data Sources: YRRS 2003, New Mexico; NMSU study on WIC clients, Ellyn Satter, "Child of Mine"; and the National Survey of Children's Health/CDC/NCHS/SLAITS 2003

NATIONAL PERFORMANCE MEASURE 08: BIRTH RATE FOR TEENS AGE 15-17 PER 1,000 POPULATION

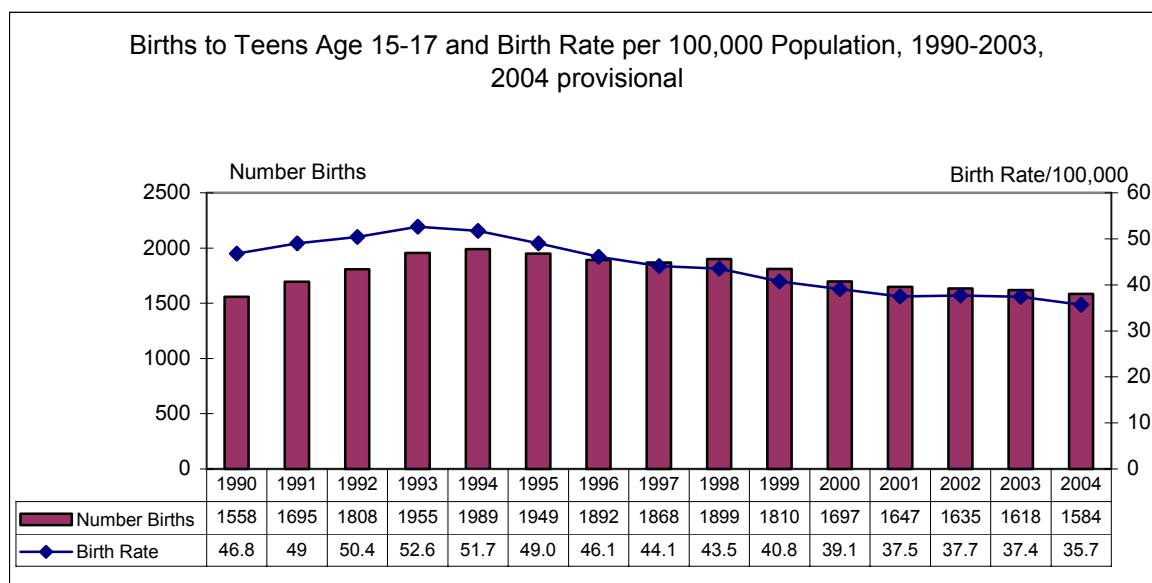
The Healthy People 2010 goals were developed in terms of pregnancies. This presents the difficulty of the under reporting for pregnancy terminations and fetal deaths, while data on rates derived from live births is more stable.

The rate of births to teens age 15-19 per 1,000 population in 2003 was 42 for the United States and 61.1 for New Mexico; the NM rate was 1.45 times the US rate. Significant disparities by race and ethnicity were reported for NM teens.

TEEN BIRTH RATES, AGE 15-19, BY RACE AND ETHNICITY New Mexico 2001-2003 and the United States 2002				
	NM Population Female 15-19	NM Births 15-19	NM Birth Rate 15-19	US Birth Rate15-19
Asian / Pacific Islander	1,257	20	16.2	18.3
American Indian / Alaska Native	10,168	607	59.7	53.8
Black / African-American	1,989	90	45.4	66.6
White Non-Hispanic	26,064	857	32.9	28.5
White Hispanic	33,994	2,941	86.5	83.4

NM Births and Birth Rates are Yearly Averages for Period 2001-2003; Population is from 2002 (UNM-BBER); Birth numbers from NMDOH, BVRHS. US birth Rates are for 2002, source www.teenpregnancy.org. Provided by T.Scharmen, MPH, NM DOH.

The federal Title V MCH Program places emphasis on births to teens age 15-17 for whom New Mexico has seen a decrease in the rate of births from 49/1,000 population to 35.7/ 1,000 population (females 15-17).

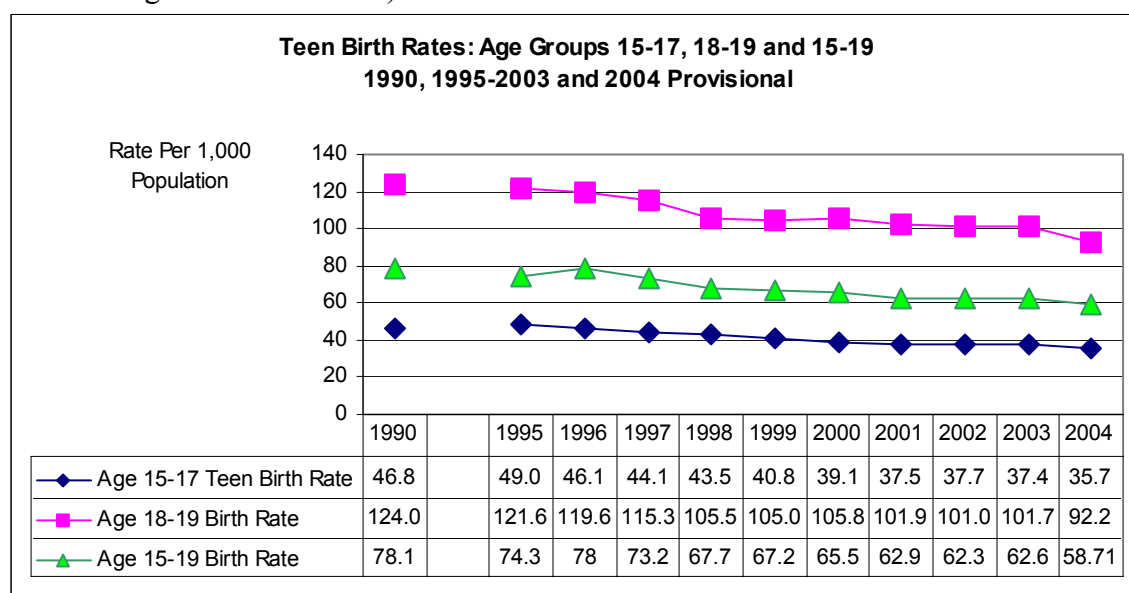


Source

: VRHS

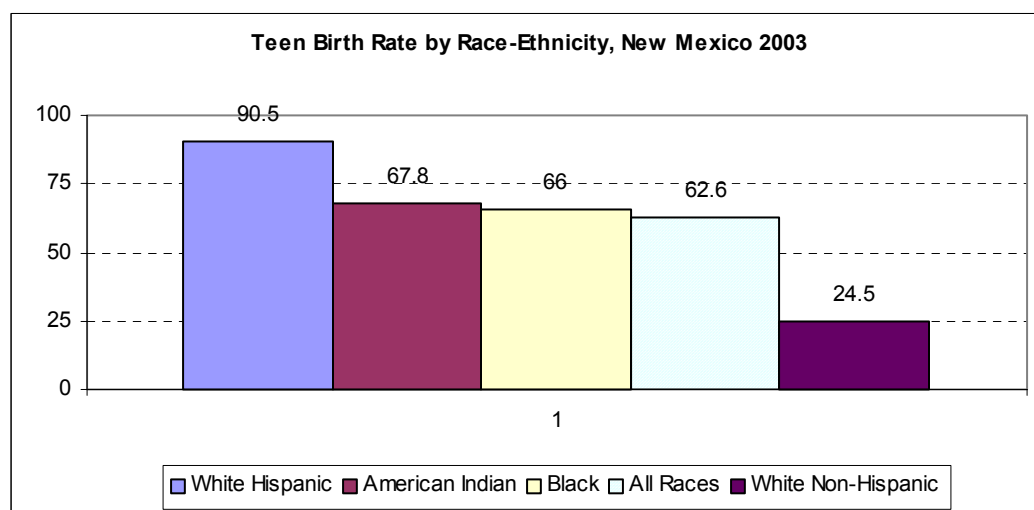
Setting the performance objective, 2005-2009: The average annual rate of decrease in the birth rate for teens 15-17, for the period 1995-2004 was 0.04% (note that 3 year averages were used to obtain this rate). This estimate will be applied to targets for the period 2005-2009.

The NM DOH priority is on teens age 15-19; births to teens age 15-17 are encompassed in this initiative. Trends in rates for the two subgroups 15-17 and 18-19, and the trend for ages 15-19 were analyzed; there has been an 11% decrease in the rate for age 15-19 in past 10 years (about 2.7% average annual decrease).



Source: VRHS

There are significant differences in rates by race-ethnicity among teens 15-19; these differences have persisted over the past 10 years. Many factors are associated with these differences: cultural norms, poverty versus socio-economic advantage and others.



The NM PRAMS Surveillance Report 2001-2002 has extensive details about the health of pregnant and parenting teens, and their access to/use of recommended health care. The report is available at www.health.state.nm.us.

TEEN PREGNANCY PREVENTION IS A PRIORITY OF THE NM DEPARTMENT OF HEALTH.

Background: The NM Youth Risk Resiliency Survey (YRRS) – the NM equivalent of the CDC Youth Risk Behavior Survey (YRBS). Age at first intercourse and number of sexual partners is associated with increased risk for unwanted pregnancy and other sexually transmitted diseases, including HIV infection.

2003 New Mexico YRRS Results for Sexual Activity: Not all districts who agreed to participate in the YRRS allowed questions about sex. Therefore, the following data represent most, but not all, of the participating districts.

A two-fold increase was reported in the number of New Mexican adolescents who had sexual intercourse before age 13: 5% in 2001 and 10% in 2003.

In 2003, 48% of NM youth in Grades 9-12 indicated they had ever had sexual intercourse (a non-significant increase from 44% in 2001). Among those who had ever had sexual intercourse:

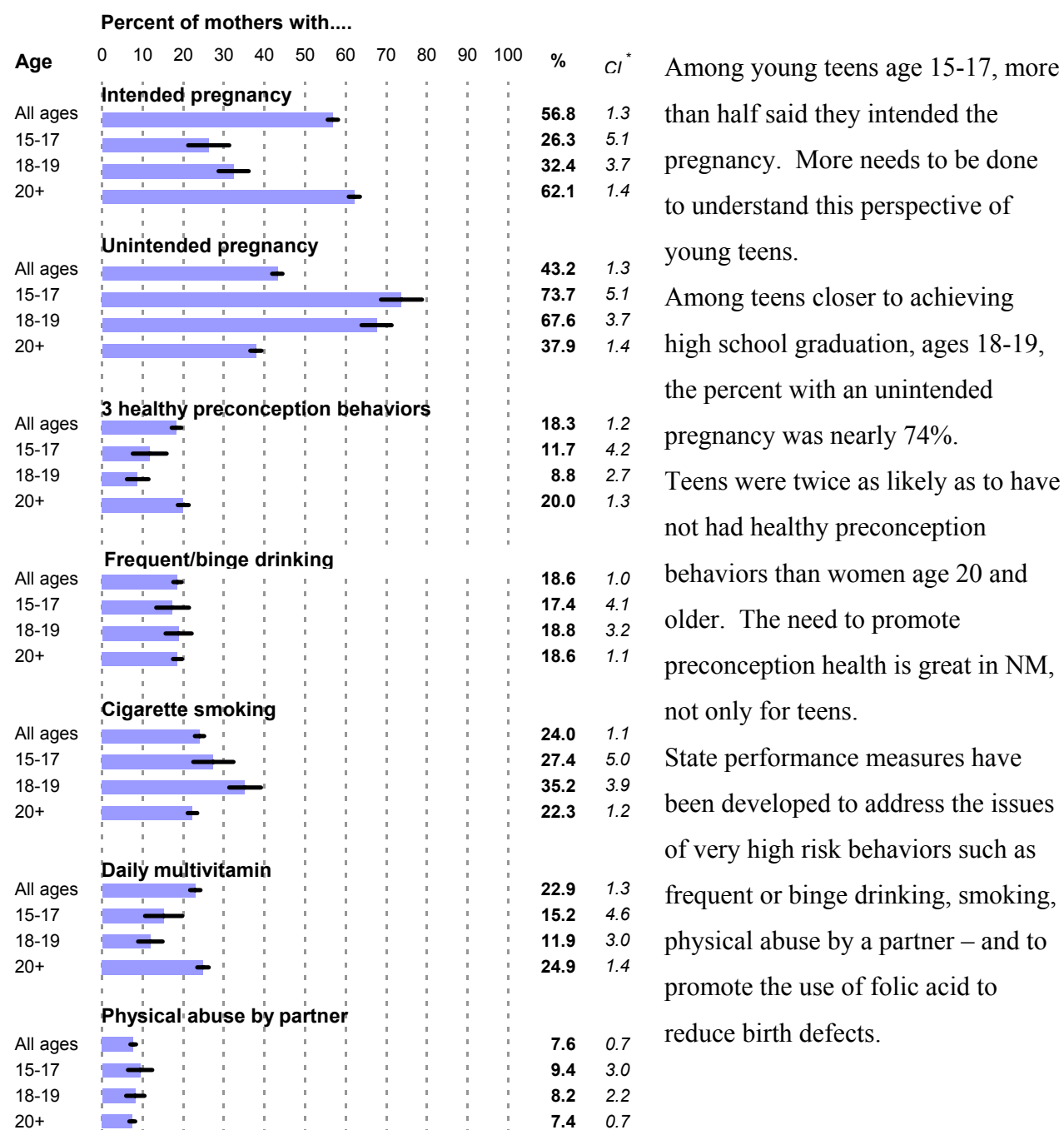
- ❖ 19% reported having had sexual intercourse with one person during their lifetime,
- ❖ 15% had 2-3 partners, and
- ❖ 13% indicated 4 or more partners

In 2003 14% said alcohol or drugs were used before having had sexual intercourse the last time, and 28% percent said a condom was used the last time they had engaged in sexual intercourse (unchanged from 2001).

The entire text of the NM YRRS is available online at www.health.state.nm.us. The data are used extensively by community groups for whom county-specific estimates are available.

The 2001-02 NM PRAMS surveillance report provides critical insight into the issues of intention of pregnancy and use of contraception by teens. Among teens who had a live birth between 1998-2002:

SELECTED CHARACTERISTICS OF TEEN MOTHERS, NM 1988-2002



Use of contraception among teens who had a live birth suggests avenues for prevention:
Among those with unintended pregnancy, percent who used contraception at the time of conception:

- ❖ ~40% teens age 15-17
- ❖ 39% teens age 18-19

Among those with unintended pregnancy, percent who did not use contraception at the time of conception:

- ❖ ~60% teens age 15-17
- 61% teens age 18-19

Prevention of unintended pregnancy among NM teens requires continued efforts to assure that effective methods are easily accessed and that teens (both male and female) understand correct use. The emergency contraceptive pill – available in NM through clinics or pharmacies since 2004, may help to avert some of the unintended pregnancies.

In 1998, the NM Family Planning Program launched a program entitled “Challenge 2005: Reducing Teen Pregnancy in New Mexico”. It asked counties to reduce their teen birth rate 20% by 2005. In 2005, using 2003 that was the most current county specific data, there was an overall 11% reduction in teen births; significant progress was noted:

District I		
County	% Change	Births
Torrance	-49%	30
Cibola	-16%	81
San Juan	-16%	311
McKinley	-14%	216
Bernalillo	-7%	1180
Sandoval	-6%	163
Valencia	-2%	199

District II		
County	% Change	Births
Los Alamos	-67%	5
San Miguel	-36%	52
Colfax	-25%	26
Union	-21%	8
Santa Fe	-12%	238
Rio Arriba	-6%	148
Taos	9%	66
Mora	78%	10
Harding	.	1

District III		
County	% Change	Births
Catron	-39%	3
Socorro	-26%	45
Luna	-25%	88
Grant	-23%	72
Sierra	-21%	22
Otero	-10%	139
Hidalgo	-5%	15
Dona Ana	18%	605

District IV		
County	% Change	Births
Quay	-53%	13
De Baca	-31%	4
Eddy	-31%	145
Guadalupe	-29%	10
Chaves	-26%	171
Lincoln	-15%	28
Lea	-13%	223
Curry	-7%	148
Roosevelt	19%	57

The tables above show the results by Public Health District, and by order of the decrease. The numbers of births in 2003 are shown to gauge the dimension of the effort and to interpret the percent change. Thirty of the state's 33 counties reported a reduction between 1998-2003; only 3 counties reported an increase over this period. Fourteen of the counties achieved a decrease of 20% or greater. The tables produced by the program do not feature statistical testing; but rather provided the counties with a score, irrespective of the number of teens or number of births.

The Title V Abstinence Education Program is a program of the Family Health Bureau with the goal to build developmental assets of youth and promote abstinence and decision making for healthy life. In the recent past the Abstinence Education Program focused on middle and high school students, beginning July 1, 2005 the Department will use Title V funding to provide curriculum-based services to students in the sixth grade. National research has indicated that abstinence programs work best among young people who have not yet engaged in sex. The middle school version of YRRS in 2002 reported high numbers of middle school attendees having had sex: 30% of 8th graders, 20% of seventh graders and 15% of sixth graders.

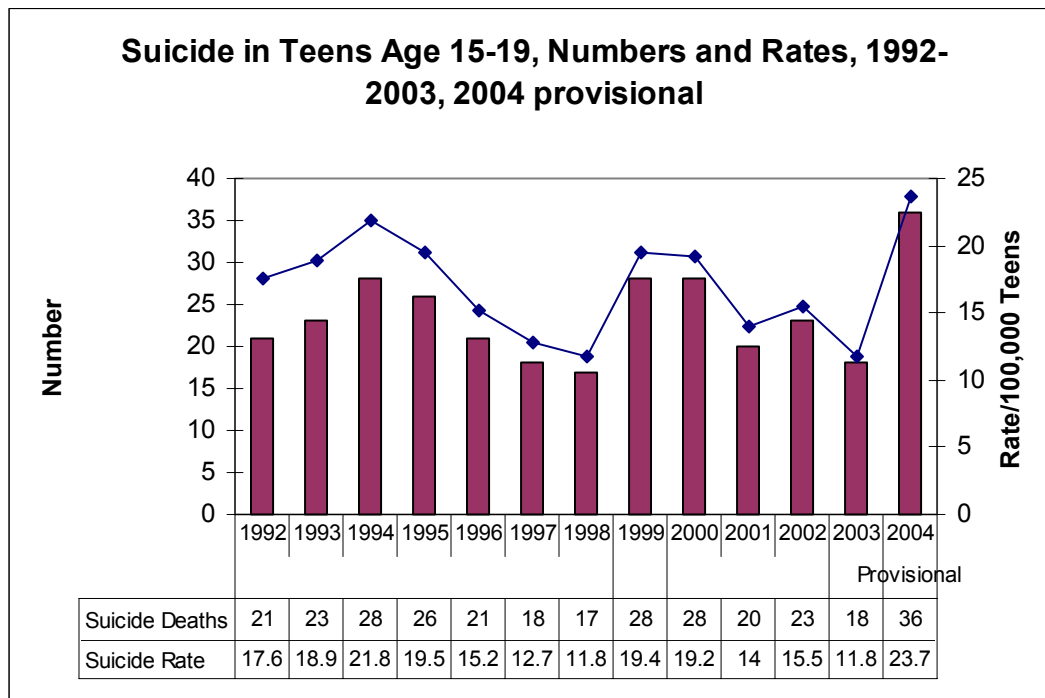
HEALTH OF NEW MEXICO YOUTH –TEEN SUICIDE PREVENTION

NATIONAL PERFORMANCE MEASURE 16, THE RATE (PER 100,000 POPULATION) OF SUICIDE DEATHS AMONG YOUTHS AGE 15-19

The Healthy People 2010 Goal is to reduce the teen suicide the suicide rate to 6.0 per 100,000 population. This goal is related to objective 18-10, to reduce the rate of suicide attempts by adolescents in grades 9-12 to a 12-month average of 1 percent.

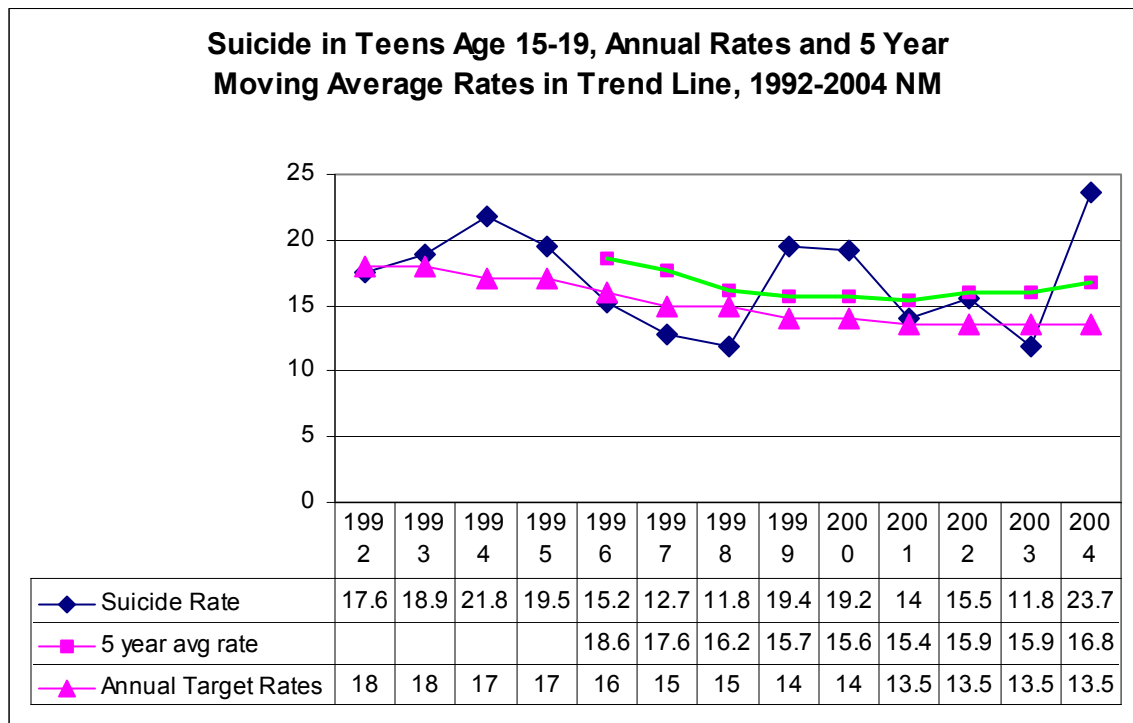
Healthy People 2010 includes the following national measures related to adolescent suicide, • Reduce the proportion of children and adolescents with disabilities who are reported to be sad, unhappy, or depressed as well as eliminate the disparity between children with disabilities and those without; and to increase the proportion of children with mental health problems who receive treatment.

Teen suicide rates are as unpredictable as suicide itself; and, in a state the size of NM the numbers are small from a statistical point of view.



Analysis of Trend, Setting New Targets: The average annual percentage change in rates between 1992 and 2004 was 7.514%; the 5 year percentage change was 11.33.

In light of trend analysis – with highly variable rates and a small number of events - It is unwarranted to change the state targets at this time; the state target will remain 13.5 per 100,000 population through 2009.



Completed suicide is more common in adolescent and young adult males than in females (male:female ratio of 3:1 in pre-pubertal suicides; 5.5:1 among 15- to 24-year-olds). However, suicide attempts are three times more common in girls than in boys. In New Mexico, in 2002, nearly 60% of the 197 hospitalizations for suicide attempts among youth were female and nearly half were Hispanic.

Attempted suicide rates are highest for Native American youth and higher for Hispanic youth than for White and African-American youth.⁶² Suicide completions (deaths) are

also higher among Native American youth and Hispanics than among White non-Hispanics and African-Americans in New Mexico.

Risk Factors: Untreated depression and substance abuse are major risk factors for suicide and suicide attempts. **Psychopathology:** More than 90% of youth who commit suicide have a mental health problem, although younger adolescent suicide victims have somewhat lower rates of psychopathology, averaging around 60%.⁶ Depressive disorders are consistently the most prevalent disorders among adolescent suicide victims, ranging from 49% to 64%.⁶⁴ Most children who need a mental health evaluation do not receive services. Hispanics and the uninsured have especially high rates of unmet need relative to other children.⁶⁵

National data also indicate that 20% of children may have a mental health problem at any one time and 70% of those identified as having a mental health problem are unable to access treatment. **Substance Abuse:** Substance and/or alcohol abuse significantly increases the risk of suicide in teens ages 16 and older. According to the 2000 National Household Survey on Drug Abuse (NHSDA), youth who reported past year use of any illicit drug other than marijuana were almost three times more likely to be at risk for suicide than youth who did not use. While risk factors for both boys and girls include previous attempts and depression, additional risk factors for boys are disruptive behavior and substance abuse. In 1997, of the 63 New Mexico youth 15-24 years old that died by suicide, 58 had toxicology tests performed. They revealed that 29 (50%) tested positive for drugs or alcohol. Eighteen of those who tested positive were over the legal limit for intoxication.⁶⁶

Violence & Abuse: National data show that having been a victim of violence or abuse increases risk for suicide in youth.⁶⁷ Children who witness domestic violence are six times more likely to commit suicide before the age of 16. In addition, having been a victim of child sexual abuse was reported among 9% to 20% of adults who have attempted suicide. Childhood physical abuse has been found to be associated with an increased risk of suicide attempts in late adolescence or early adulthood.⁶⁸ Girls that

were victims of dating violence were 8-9 times more likely to have attempted suicide in the previous year.⁶⁹

Sexual Orientation: The National Longitudinal Study of Adolescent Health indicates that youth with same-sex orientation are more than twice as likely to attempt suicide as their peers. According to an analysis of 12 studies on youth suicide attempts in the Gay-Lesbian-Bisexual population, 30.5% attempted suicide and 44.1% re-attempted suicide.⁷⁰

Law Enforcement/Corrections: Some studies suggest that youth who have contact with the juvenile justice system are more at risk for suicide. One study showed that, among youth ages 13-21 who committed suicide in one state, 63% had contact with juvenile justice. There was also a correlation between the number of juvenile justice contacts and suicide risk.⁷¹

Access to Firearms: Of the suicide deaths of youth aged 18 or under in New Mexico in 2002, firearms were the mechanism of completion in 63% of the suicides.⁷² In one national study, the availability of guns in the home, independent of firearms type or method of storage, appeared to increase the risk for suicide among adolescents.⁷³ In the 2001 New Mexico Youth Risk and Resiliency Survey (N=9,122 students) 40.5% of high school students said they could get a gun or rifle within 15 minutes to one day and 25% said they could get a firearm from their home. In 2002, 67.7% of New Mexico households contained a loaded, unlocked firearm.⁷⁴

Stigma: Stigma has been identified as the most formidable obstacle to future progress in the area of mental health.⁷⁵ It is a key reason that certain ethnic groups are particularly disinclined to seek treatment for mental illness or substance abuse.⁷⁶ Stigma is intense in rural areas⁷⁷ and it is implicated in the low percentage of youth and the elderly with mental disorders – both groups at high risk for suicidal behavior who receive mental health services.⁷⁸

Access to Care: Access to appropriate treatment decreases suicide rates. A national study suggests that the increased use of antidepressants among children 10 to 19 years of age has been accompanied by a significant decrease in the suicide rate in this age group. For a 1% increase in the use of Selective Serotonin Reuptake Inhibitor antidepressants (SSRIs)

among adolescents, there was a decrease of 0.23 suicides per 100,000 adolescents per year.⁷⁹

Protective Factors: In a study of 10,700 students,⁸⁰ schoolchildren with a history of suicide attempts were compared to schoolchildren without such history with respect to mutable home, school, and community factors. Children and youth least at risk felt they mattered to their parents and their community and lived in places where adults made them feel important and listened to them. The study showed that youth suicide prevention should involve a coordinated effort to address resiliency factors in all the developmental stages of a child's life. The early parent/child relationship piece is an opportunity to improve New Mexico suicide prevention efforts.

Access and Capacity Issues: Identification, evaluation and treatment are critically important in the effort to combat suicide, yet, according to the 2002 Behavioral Health Needs & Gaps in New Mexico, behavioral health services in New Mexico are inadequate, difficult to access and poorly geographically distributed. With only 12 child psychiatrists in New Mexico outside of Albuquerque and Santa Fe, even more limited psychiatric services are available in rural and frontier New Mexico. The Gaps Analysis also found that 80% of psychiatrists, 70% of psychologists, 47% of social workers, and 53% of counselors are concentrated in Bernalillo and Santa Fe Counties, and most of these have no training in working with children or adolescents.

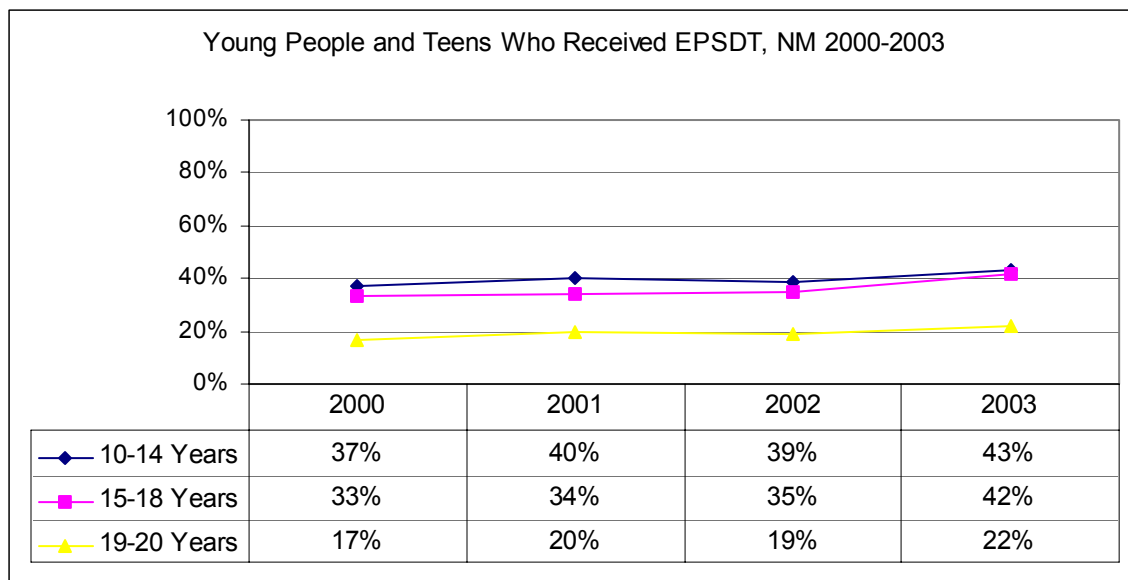
New Mexico has fewer mental health professionals than other states:

- Psychiatrists (13.7 per 100,000 population vs. 14.2 U.S. average);
- Psychologists (25.2 vs. 28.4); and
- Social workers (31.2 vs. 36.2).

New Mexico Schools are also underserved. In 2002, a survey of New Mexico public schools was conducted to determine the levels of community mental health and substance abuse evaluation and treatment provided by non-school district employees to students in the schools. This study found that 54.6% report they are receiving no community mental health provider services and 93% would request an increase in mental health service hours, if available.

Educational/Training Programs for Primary Care Physicians and Pediatricians:

National data suggest that primary care providers prescribe 70% of the psychotropic medications in the U.S., even though they have little behavioral health training. The national and state need for training primary care physicians is highlighted by the finding that, while 72% of 600 family physicians and pediatricians in North Carolina had prescribed a SSRI (Selective Serotonin Reuptake Inhibitor antidepressant) for a child or adolescent patient, only 8% said they had received adequate training in the treatment of childhood depression and only 16% reported that they felt comfortable treating children for depression⁸¹ - - this, despite the fact that SSRIs have been shown to decrease adolescent suicide.



EPSDT screening: The Early Periodic Screening Diagnosis and Treatment (EPSDT) component of Medicaid services has not prioritized the behavioral health component of screening in the past. As a result, there is an increased possibility that behavioral health issues of children and adolescents are not recognized, since they are not raised as part of this critical process. The proportion of young people who receive EPSDT screening is low.

D. Best Practices

1. School-Based Suicide Prevention Programs

Skills Training: Skills training programs emphasize the development of problem solving, coping, and cognitive skills, as suicidal youths have deficits in these areas. School curricula on suicide must be carefully planned in order to avoid disturbing students already at high-risk for suicide. Several evaluation studies, especially those reviewing longer-term approaches, have shown promising results, with some evidence for reductions in attempted and completed suicides.⁸²

Gatekeeper Training: Programs to train school personnel as gatekeepers are based on the premise that suicidal youth are under-identified and that identification could be increased by providing adults with knowledge about suicide. Research examining the effectiveness of gatekeeper training is limited, but the findings are encouraging, with significant improvements in school personnel's knowledge, attitudes, intervention skills, preparation for coping with a crisis, referral practices and general satisfaction with the training.⁸³

2. Community-Based Prevention Programs

Restriction of Firearms: The underlying rationale for firearm restrictions is that, since suicidal individuals are often impulsive, they may be ambivalent about killing themselves, and the risk period for suicide is transient. Several studies have found that restrictions on guns reduced the overall suicide rate as well as reducing firearm-related suicides.

Media Education: Given the substantial evidence for suicide contagion, a recommended suicide

prevention strategy involves educating media professionals about contagion, in order to yield stories that minimize harm. Moreover, the media's positive role in educating the public about risks for suicide and shaping attitudes about suicide should be encouraged. This strategy has been successful in Austria and Switzerland.

3. Screening and Early Identification Programs

Screening Models. A strategy that has received increased national attention is case finding through direct screening of individuals. Self-reports, utilizing computers and individual interviews, are used to identify youth at risk for suicidal behavior. These models are being implemented in schools, juvenile justice programs, and primary care

settings in New Mexico and around the country. Of primary concern is the need to have enough providers available to evaluate and treat those who screen positive. Without resources to which to refer adolescents for treatment, screening is useless and, in fact, may increase liability.

4. Treatment

“The burden on professionals to identify depressed and suicidal teenagers and bring them to treatment is greater than ever before...given the complexity of the mechanism of youth suicide, . . . a comprehensive, integrated effort, involving multiple domains -- the individual, family, school, community, media, and health care system -- is needed.”⁸⁴

Psychotherapy: Cognitive Behavioral Therapy (CBT) is a best practice for treating adolescent depression. Key CBT elements include: (1) a collaborative relationship between client and therapist, (2) psychological distress viewed as a disturbance in cognitive processes (therefore, one works to change cognitions to change behavior), (3) time-limited therapy that also provides psycho-educational treatment on specific problems.

Currently, the Office of School Health, in collaboration with the University of New Mexico, is providing CBT training to mental health and primary care providers, working with students at selected rural New Mexico SBHCs. Interpersonal Psychotherapy (IPT) is another psychotherapy model for treatment of depression that has been proven effective in numerous studies. IPT is a brief and highly structured manual-based psychotherapy that addresses interpersonal issues. It aims to decrease symptoms by helping improve social interactions.⁸⁵

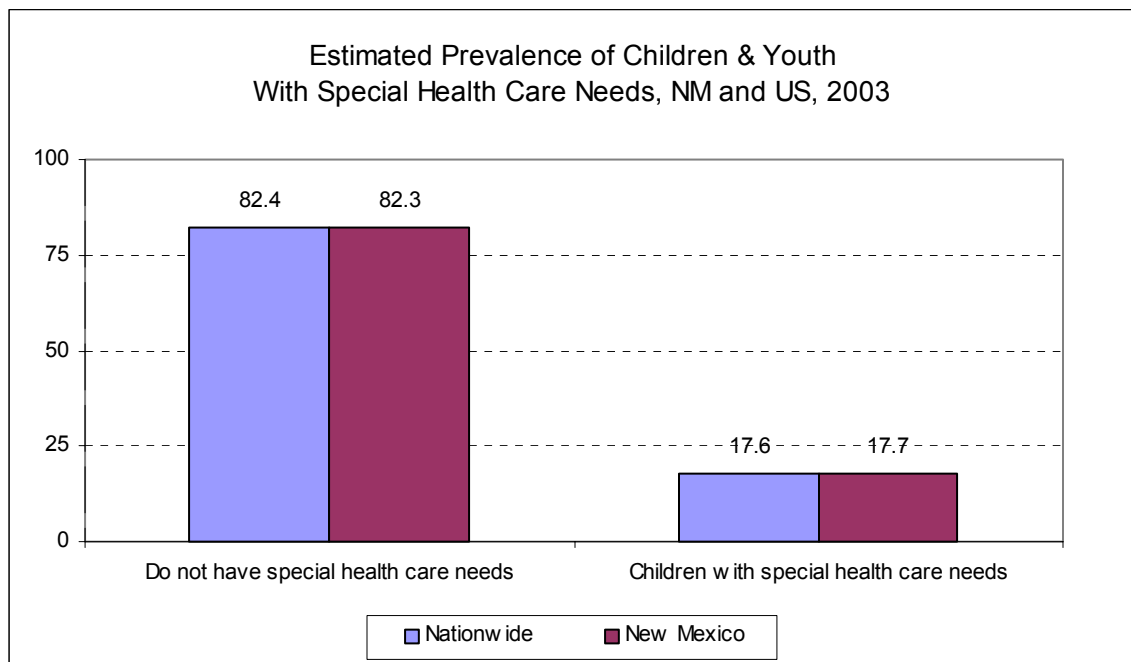
Psychopharmacological: Recently the issue of using antidepressants to treat adolescent depression, with the exception of fluoxetine (Prozac), has become more controversial. A recent study concluded, however, that “An inverse relationship between regional change in use of antidepressants and suicide raises the possibility of a role for using antidepressant treatment in youth suicide prevention efforts, especially for males, older adolescents, and adolescents who reside in lower-income regions.” For each 1 percent increase in the use of antidepressants among adolescents, there was a decrease of 0.23 suicides per 100,000 adolescents per year.⁸⁶

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS

The Title V MCH definition of this population includes all children

- who have, or are at increased risk for, chronic physical, developmental, behavioral, or emotional conditions and
- who also require health and related services of a type or amount beyond that required by children generally.

An estimated 17.7% of NM children and youth age 0-17 have special health care needs; a similar estimate to the nation.



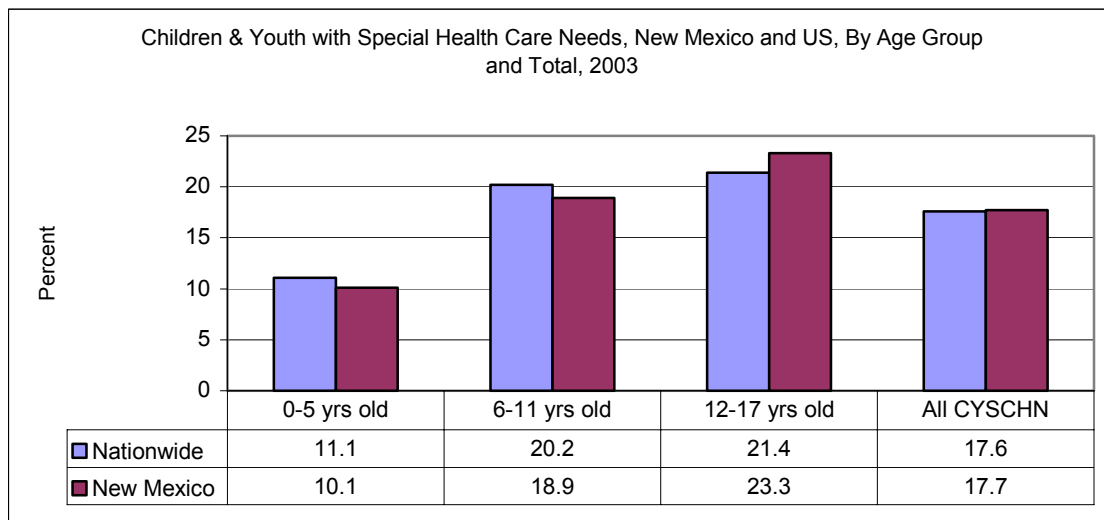
Source: Compiled from Data Obtained from Child & Adolescent Health Measurement Initiative (2005). National Survey of Children's Health, Data Resource Center on Child & Adolescent Health, website www.nschedata.org.

According to the National Children's Health Survey (NCHS) there were an estimated 88,375 CYSHCN in New Mexico in 2003; this estimate may be low because the NSCH used a survey estimate of 499,992 NM children. The New Mexico intercensal estimate for 2003 was 511,2903 – a difference of over 11,000 children.

In 2001, the estimate of CYSHCN for the state and the nation was 11%, based on the National Survey of Children with Special Health Care Needs. Researchers at the Data Resource Center on Child and Adolescent Health examined the two surveys and determined that the overall population estimates in 2001 were low due to methodological differences with the NSCH in 2003. While the overall estimates were low; the intra-

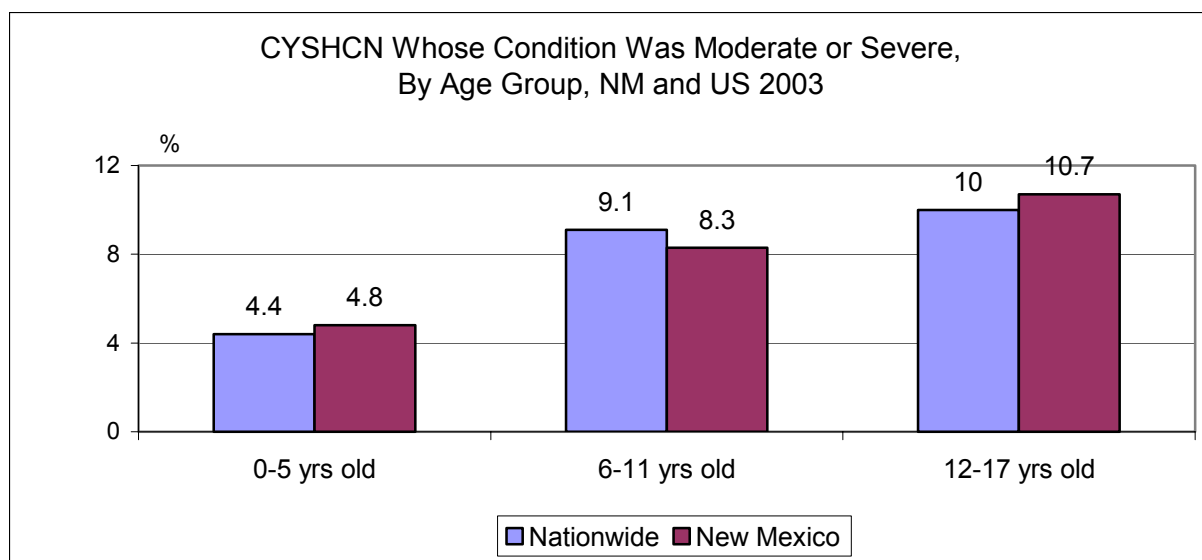
population estimates for program characteristics are not thought to be affected. (Personal communication, C.Bethell, PhD)

In both NM and the US, the distribution of the population of CYSHCN is lowest for children <6 years of age, thought to be due to the age of children when diagnoses are made, particularly for chronic conditions rather than conditions originating in early years of life such as sequelae of birth defects or low birth weight.



Source: Compiled from Data Obtained from Child & Adolescent Health Measurement Initiative (2005). National Survey of Children's Health, Data Resource Center on Child & Adolescent Health, website www.nschedata.org.

Of CYSHCN whose condition was moderate or severe, the age distribution was similar to the distribution of all CYSHCN. Referring to the age distribution of all CYSCHN, this table indicates that about half of children in the three age groups have a moderate or severe condition, and the other half have conditions that are minor or not currently affecting the child.



Source: Compiled from Data Obtained from Child & Adolescent Health Measurement Initiative (2005). National Survey of Children's Health, Data Resource Center on Child & Adolescent Health, website www.nschedata.org.

The NM data for race ethnicity had very small cells for black, multi-racial and other children (the other category included Native Americans in the New Mexico sample) and thus are not reported. Nationwide the prevalence was 17.6% (CI 17.2, 18.0): white and black children had similar prevalence to the national estimate; children less likely to have special needs were Hispanic at 11.4% (CI 10.4, 12.4); those with higher prevalence were multi-racial children at 23.6% (CI 21.0, 26.2). This report merits continued evaluation over time.

Additional analysis of CYSHCN from the newly released NSCH will be forthcoming, to aid the DOH in its work to address the needs of this population.

Youth in Transitional Age Group 18-24

The NM Behavioral Risk Factor Surveillance System (BRFSS) is one source of data that can be used to examine all youth in the transitional age group 18-24 years. The 2000 BFRSS data (seen here) were compared to 2002 data (most current available) and there were no significant differences; indeed, most estimates remained the same.

Data from NM BRFSS on youth in transition age group 18-24

Year 2000

Indicator	Weighted Percent	95% Confidence Interval
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HEALTH STATUS

Stated their health was fair or poor		
All New Mexicans	16.90%	" 1.4
Youth Age 18-24	8.30%	" 3.5
Felt healthy and full of energy in the past 20 days		
All New Mexicans	65.20%	" 1.9
Youth Age 18-24	65.00%	" 6.1
Arthritis		
All New Mexicans	21.70%	" 1.5
Youth Age 18-24	5.00%	" 2.9
Presumptive arthritis (diagnosis and/or chronic joint pain)		
All New Mexicans	31.60%	" 1.8
Youth Age 18-24	14.60%	" 4.6
Asthma, told they have it		
All New Mexicans	10.80%	" 1.2
Youth Age 18-24	13.90%	" 4.5
Asthma, currently have it		
All New Mexicans	6.80%	" 1.0
Youth Age 18-24	6.80%	" 3.3
Diabetes, told by doctor they have it		
All New Mexicans	6.20%	" 0.9
Youth Age 18-24	0.30%	" 0.6
Overweight based on BMI of 25-29.9 (self report of height and weight)		
All New Mexicans	37.50%	" 2.0
Youth Age 18-24	24.80%	" 5.6
Obese based on BMI ≥ 30 (self report of height and weight)		
All New Mexicans	19.70%	" 1.6
Youth Age 18-24	7.20%	" 3.0

DISABILITY

Reported having a disability (see text)

All New Mexicans	25.50%	" 1.7
Youth Age 18-24	17.70%	" 5.0

Reported being limited in any way in any activity because of physical, mental or emotional problems

All New Mexicans	18.40%	" 1.5
Youth Age 18-24	9.10%	" 3.5

Have trouble learning, remembering or concentrating because

Data from NM BRFSS on youth in transition age group 18-24		Year 2000	
Indicator		Weighted Percent	95% Confidence Interval

of any impairment or health problem

All New Mexicans	12.00%	" 1.3
Youth Age 18-24	10.00%	" 4.1

Use special equipment because of any impairment or health problem

All New Mexicans	5.70%	" 0.8
Youth Age 18-24	1.00%	" 1.4

Require care for personal or routine needs

All New Mexicans	6.40%	" 1.0
Youth Age 18-24	3.00%	" 2.4

HEALTHY OR HEALTH RISK BEHAVIORS

Binge drinking: =/more than 5 drinks on one occasion in past month

All New Mexicans	15.80%	" 1.5
Youth Age 18-24	27.30%	" 5.7

Heavy drinking:males 2 or more drink/day in past month; female 1 drink

All New Mexicans	5.00%	" 0.8
Youth Age 18-24	7.50%	" 3.3

Unaware that there are medical treatments that can reduce the chances of a pregnant woman from passing HIV to her baby

All New Mexicans	49.20%	" 2.2
Youth Age 18-24	44.10%	" 6.2

Engaged no physical activities during the past month

All New Mexicans	25.80%	" 1.7
Youth Age 18-24	18.90%	" 4.7

Don't meet recommended levels of physical activity

All New Mexicans	49.80%	" 2.0
Youth Age 18-24	40.20%	" 6.2

Keep firearms in or around the home

All New Mexicans	34.90%	" 1.9
Youth Age 18-24	24.80%	" 5.4

ACCESS TO HEALTH CARE

Said they did not have any kind of health care coverage

All New Mexicans	22.50%	" 1.8
Youth Age 18-24	38.20%	" 4.8

Needed medical care in past 12 months but couldn't get it

All New Mexicans	7.20%	" 1.0
Youth Age 18-24	11.30%	" 3.8

USE OF HEALTH CARE

Data from NM BRFSS on youth in transition age group 18-24

Year 2000

Indicator	Weighted Percent	95% Confidence Interval
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Saw a doctor, nurse or other health professional to get care in past 12 months

All New Mexicans	27.80%	" 1.8
Youth Age 18-24	33.50%	" 6.0

did not see doc for routine checkup in past 12 months

All New Mexicans

Youth Age 18-24

OTHER CHARACTERISTICS OF YOUTH AGE 18-24

Stated they were either dissatisfied or very dissatisfied with their lives

All New Mexicans	4.50%	" 0.8
Youth Age 18-24	2.20%	" 2.2

Stated they do not get the social or emotional support they need

All New Mexicans	7.90%	" 1.0
Youth Age 18-24	3.70%	" 2.1

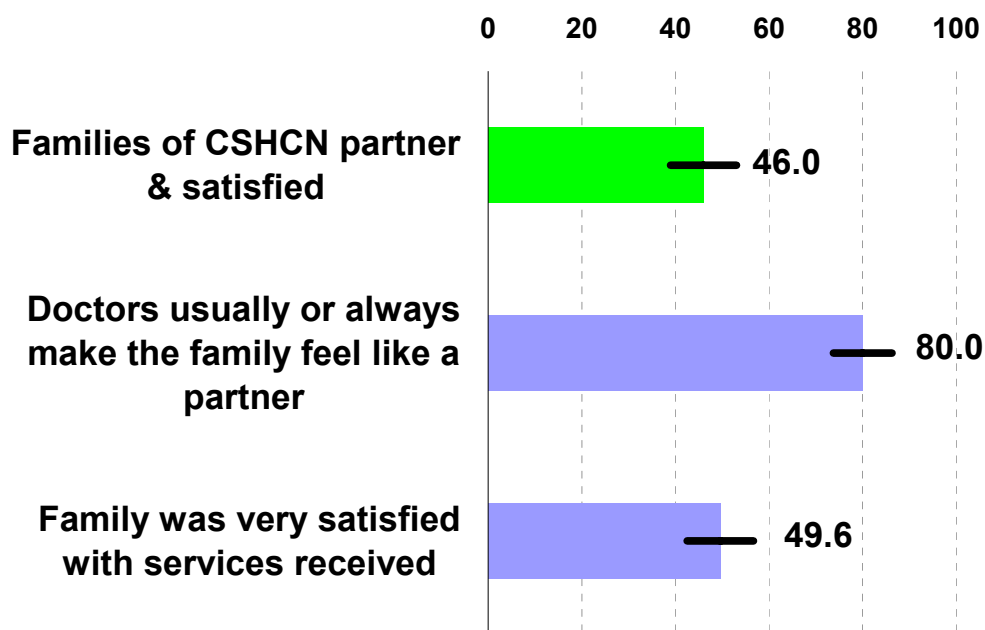
CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS

Performance Measure 02. The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive (CYSHCN survey).

Related to HP 2010 Objective 16.23: Increase the proportion of states and jurisdictions that have service systems for children with or at risk for chronic and disabling conditions as required by PL 101-239.

Most currently available data (CSHCN survey conducted in 2001) showed that in NM, 46% of the families of CSHCN feel they have partnered in decision-making and are satisfied with the services received.

STANDARD: FAMILIES OF CYSHCN WILL PARTNER IN DECISION-MAKING & WILL BE SATISFIED WITH THE SERVICES THEY RECEIVE



While most (80%) families surveyed in NM feel that they partner in decision-making, only 49.6% reported feeling “very satisfied” with the services they received. Nationally, 84.3% of families surveyed feel they partner in decision-making, and 60.1% reported feeling “very satisfied” with services received.

The new National Survey of Children's Health 2003 will be used to evaluate trends in this indicator during 2005-2006.

Not all providers and/or agencies and institutions are trained to be inclusive in family participation in decision-making. Families also experience cultural and linguistic barriers. Some families in New Mexico face economic and socio-political barriers.

Lack of support and empowerment of families may result in an increased risk for their children with special health care needs in obtaining all needed services in a timely manner, which may lead to increased morbidity and decreased quality of life. Families of CYSHCN may feel overwhelmed with their children's need for care and services; and families at risk for not receiving support may be those who lack education or who have cultural/language barriers.

A support network among families of children and youth with special health care needs may help to empower these families to obtain the needed services for their children.

Related to HP 2010 Objective 16.23: Increase the proportion of states and jurisdictions that have service systems for children with or at risk for chronic and disabling conditions as required by PL 101-239.

Evidenced based policies and programs: The Title V CYSCHN program contracts with family organizations to provide program input and training for parents and providers to increase family involvement in decision making at all levels. Family members are participants in advisory committees such as the newborn genetic and hearing screening programs. Family members of diverse cultures are involved in trainings and program input. Per Family Organizations, the Title V Program contracts for family involvement due to their guidance that family members not be hired and co-opted. Family Voices (FV) developed the Workbook for Families to Participate with States in the Development of Title V Block Grants utilizes the FV evaluation tool regarding family involvement in decision making.

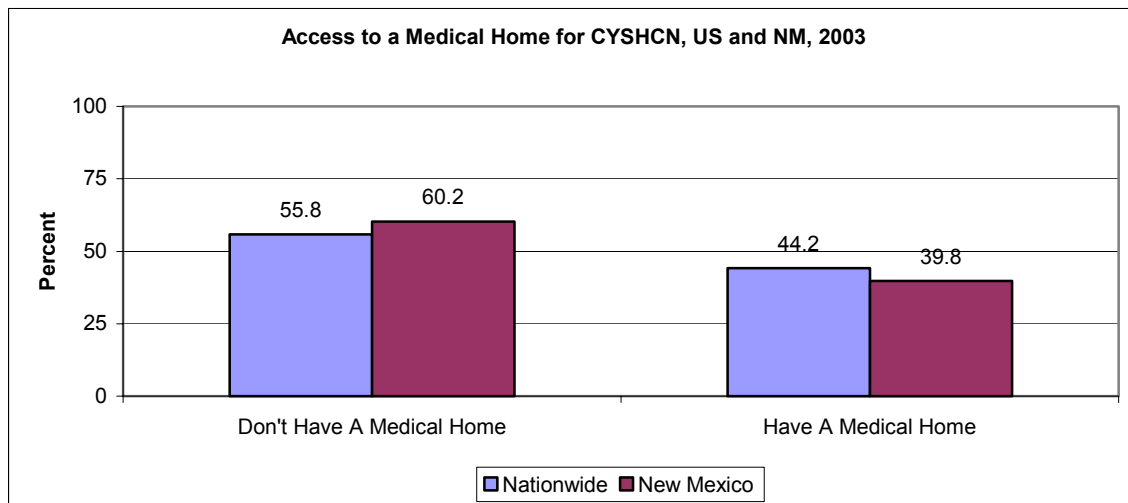
CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS

Performance Measure 03. The percent of children with special health care needs age 9 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.

Related to HP 2010 Objective 16.22 (developmental): Increase the proportion of children with special health care needs who have access to a medical home.

Children and youth with special health care needs (CYSHCN) who lack coordinated comprehensive care in a medical home may not receive all of the care and services needed for optimal growth and development, and may lead to increased morbidity and decreased quality of life. Those at risk for not having coordinated comprehensive care within a medical home may be those lacking financial and other resources, knowledge about the medical system or understanding about the needs of their CYSHCN, and those with cultural/language barriers. The National Survey of CSHCN 2001 showed that in NM, 45.4% of CSHCN received coordinated, ongoing comprehensive care within a medical home. The National Survey of Children's Health in 2003 indicates the state has lost a little ground with an estimate of 39.8% (CI 33.2, 46.4).

PERCENT OF CHILDREN AGE 0-17 YEARS AND WHO RECEIVE COORDINATED, ONGOING COMPREHENSIVE CARE WITHIN A MEDICAL HOME



Source: Compiled from Data Obtained from Child & Adolescent HealthHealth Measurement Initiative (2005). National Survey of Children's Health, Data Resource Center on Child & Adolescent Health, website www.nschedata.org.

The NSCH provided estimates for performance on selected criteria of the Medical Home concept. In 2003, for children & youth with special health care needs, age 0-17:

- ❖ 26.6% (CI 19.0-32.2) had significant problems getting the specialty care, services, or equipment recommended by their personal doctor/nurse; 72.4% had few or no problems
- ❖ 18.8% (CI 10.5-27.0) did not have a personal doctor or nurse (PDN) who was consistently available when phone advice or urgent care was needed for the child; 81.2% (CI 73.0-89.5) reported consistent availability.
- ❖ 47.7% (CI 38.2-57.1) did not have a personal doctor or nurse who follows up with family after child sees specialist or gets specialized services/equipment; 52% (CI 42.9-61.8) had consistent follow up.
- ❖ 71.3% (CI 64.9-77.6) had a personal doctor or nurse who consistently spent enough time with them and explained things in ways that children and parents could understand; 15.2% did not have this; and 13.5% of CSHCN did not have a personal doctor or nurse.

The 2001 Survey of CSHCN showed that 66.6% of families in NM (compared to 78.1% nationally) reported their children have no problems obtaining a referral when needed, and 24.8% of families in NM (compared to 37.1% nationally) reported that their doctors communicate well with other programs (e.g., schools, early intervention program, child care providers, vocational rehabilitation program). Additional analysis of the 2003 NSCH will help to understand disparities in this measure, and will be on the assessment agenda for the coming grant period.

New Mexico has a primarily rural population with barriers in access to care, specialty provider limitations, and a transient nature of the immigrant population who speak English as a second language.

The University of New Mexico collaborated with the Title V CYSHCN program in piloting the medical home model in 5 regions of the state. Limited financial resources made the implementation and success of the program very difficult.

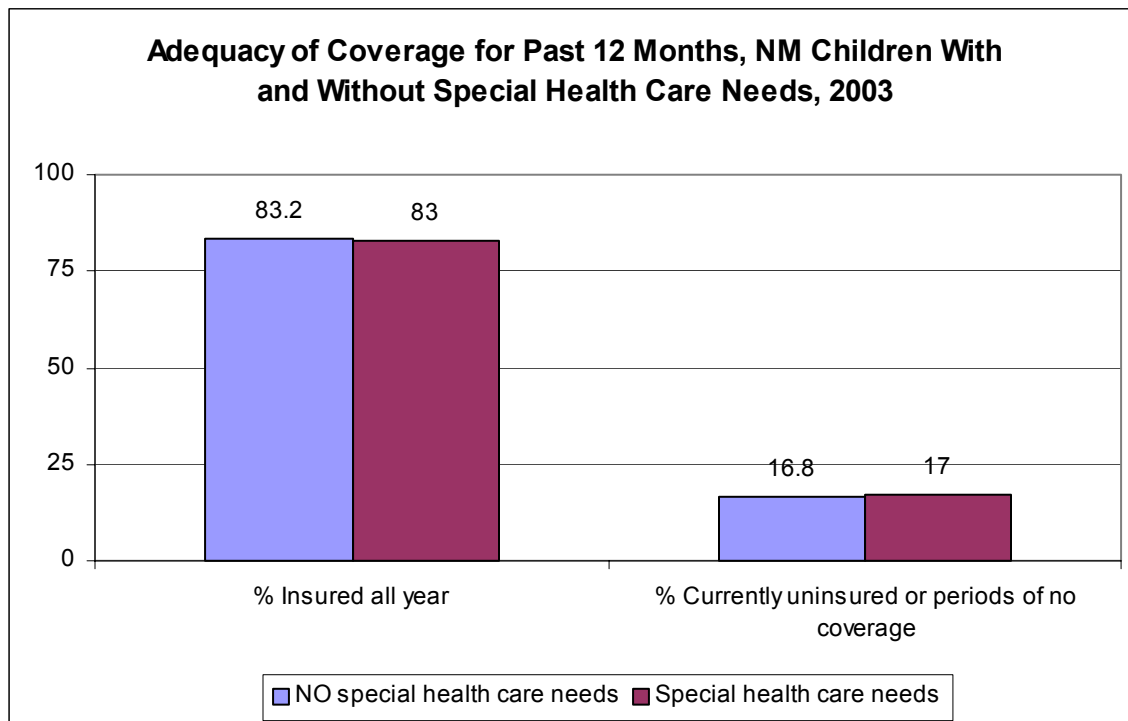
The state of New Mexico was awarded a multi-year grant to collaborate with the Title V CYSHCN program in piloting the medical home model in 5 regions of the state. Due to a small population in a large state, the partners actively collaborate to serve the children and youth with special health care needs.

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS

Performance Measure 04. The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services the need.

Healthy People 2010 Goal is related to HP 2010 Objective 16.23: Increase the proportion of States and jurisdictions that have service systems for children with or at risk for chronic and disabling conditions as required by PL 101-239.

The state program for CYSHCN set targets for insurance coverage for this population for period 2003-2008, based on data from the 2001 survey of CSHCN: 2003 – 57.4%, 2004 – 60%, 2005 – 62%, 2006 – 64%, 2007 – 66%, 2008 – 66%. An estimated 83% of NM children and youth with special health care needs had adequate insurance for the past year in 2003; 17% had gaps in coverage or had no insurance at all. Thus, it would appear, that coverage for this population is better than thought.



Source: Compiled from Data Obtained from Child & Adolescent HealthHealth Measurement Initiative (2005). National Survey of Children's Health, Data Resource Center on Child & Adolescent Health, website www.nschedata.org.

New Mexico Children without special health care needs:

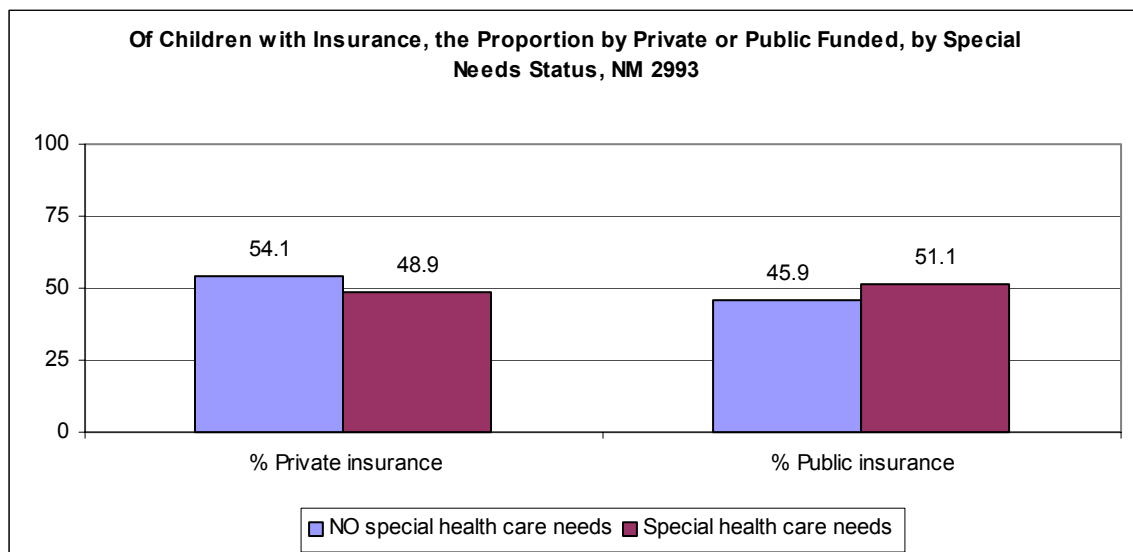
- ❖ Insured all year, 83.2% (CI 80.8 - 85.5)
- ❖ Currently uninsured or periods of no coverage 16.8% (CI 14.5 - 19.2)

New Mexico CYSHCN:

- ❖ Insured all year 83% (CI 77.0 - 89.1)
- ❖ Currently uninsured or periods of no coverage 17% (CI 10.9 - 23.0)

Overall, the coverage of all NM children improved in the period 2001-2003. Findings from the National Survey of CSHCN in 2001 showed that in NM, 57.4% families of CSHCN reported having adequate private and/or public insurance to pay for the services they need. About 20% of families did not feel that insurance usually or always meets their child's needs, and about 30% felt that costs not covered by insurance were reasonable.

More CYSHCN who have insurance, are covered by publicly funded programs than children who do not have special needs.



Source: Compiled from Data Obtained from Child & Adolescent Health Measurement Initiative (2005). National Survey of Children's Health, Data Resource Center on Child & Adolescent Health, website www.nschdata.org.

Disparities: Children and youth with special health care needs receive medical coverage through the state Medicaid/SCHIP program and the Title V CYSHCN Program. Both programs face fiscal limitations, thus resulting in the exclusion of either diagnoses, and/or treatment/procedures for CYSHCN. In addition, the Title V CYSCHN program has a

\$15,000 limit per fiscal year per child. Rural and immigrant children and youth face geographical barriers to care. In FY '04, legislation regarding Medicaid/SCHIP changed the re-enrollment period from annually to semi-annually. The New Mexico Medical Insurance Pool (NMMIP) insurance for high cost diagnoses has a six month waiting period for pre-existing conditions.

Risk Factors: Those at risk for not having adequate insurance are those lacking financial and other resources and those with cultural/language barriers.

Positive Influence Factors: Having a relationship with or connection to reliable sources of information in their communities (e.g., other parents of CYSHCN) will allow families to obtain the care/services available to them. The Title V program has begun the purchase of insurance through NMMIP for children and youth with high cost diagnoses as funds become available. Ultimately this will provide more comprehensive coverage and will assist in meeting program costs and providing better support to the medical infrastructure.

Evidenced based policies: Title V provides funding for children and youth with special health care needs. Title XVIII is the New Mexico Medicaid program and Title XXI is the SCHIP program that expanded the existing Medicaid Program. Under Title V CYSHCN program, all infants receive newborn and genetic screening and follow-up. Private insurance was legislatively mandated (FY '03) to provide metabolic food and formula to clients with metabolic diseases.

Evidenced based programs: Title V provides funding for children and youth with special health care needs. In New Mexico, the Title V CYSHCN program, Children's Medical Services provides medical coverage, care coordination and infrastructure support as well as surveillance for CYSHCN.

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS

Performance Measure 05. Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CYSHCN Survey)

Healthy People 2010: Related to HP 2010 Objective 16.23: Increase the proportion of States and jurisdictions that have service systems for children with or at risk for chronic and disabling conditions as required by PL 101-239.

Status: Most currently available data (CSHCN survey conducted in 2001) showed that in NM, 66.5% of families reported that community-based service systems are organized so families can use them easily.

Trends: Data are not sufficient to assess trends since the CSHCN survey has only been conducted once in 2001.

Gaps: Outreach efforts are needed to educate families and providers about community-based service systems that are available to them and to assist them in accessing those systems.

Disparities: New Mexico has a primarily rural population with barriers in access to care, specialty provider limitations, and a transient nature of the immigrant population who speak English as a second language. Lack of specialty care providers requires families to often travel long distances to receive consultation and treatment of conditions. The state's primary tertiary care provider has limited linguistic resources for families who speak English as a second language.

Risk Factors: Families at greatest risk for not accessing available services are those lacking knowledge/education, particularly those with cultural/language barriers and those in rural areas, isolated geographically.

Positive Influence Factors: CMS coordinates over 120 specialty care clinics statewide which includes pulmonary, neurology, cleft lip and palate, endocrine, metabolic and genetic clinics. Local community providers often participate in these clinics as well as specialists from the University of New Mexico Hospital.

Evidenced based policies: Under Title V, Children's Medical Services is the Title V Children and Youth with Special Health Care Needs Program provides community-based and coordinated care for CYSHCN.

Evidenced based programs: Title V provides funding for children and youth with special health care needs. In New Mexico, the Title V CYSHCN program, Children's Medical Services provides medical coverage, care coordination and infrastructure support as well as surveillance for CYSHCN. This includes the provision of community based, culturally competent, coordinated specialty care clinics.

Performance Measure 06. The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CYSHCN Survey)

Healthy People 2010: Related to HP 2010 Objective 16.23: Increase the proportion of States and jurisdictions that have service systems for children with or at risk for chronic and disabling conditions as required by PL 101-239.

State Targets: 2003 – 5.8%, 2004-5.9%, 2005-6%, 2006-6.5%, 2007-6.7%, 2008-6.7%.

Status: In the state of New Mexico there are more than 48,000 adolescents state-wide were recorded as having a chronic medical condition (NM-3CR, 2001). These conditions may vary in complexity and risk from those that would be considered to be relatively minor, to conditions that have the potential to be life-threatening (i.e. asthma, seizure disorders, cardiac conditions, various cancers and others). As little as two decades ago, few children with severe illnesses or disabilities survived to adulthood. Today almost 90% of children with chronic conditions live to age 21 and beyond. As this group approaches the ages of 18-21 they begin to lose many of the supports that have provided some degree of stability in their lives and consistency of treatment for their medical conditions. These may include: dropping from their parents medical insurance, losing Medicaid eligibility, or other public insurance programs (i.e. Children's Medical Services), losing the continuity provided by their childhood pediatricians, and support systems that may have been provided through their public school systems. In the year 2000, Children's Medical Services began a series of focused efforts in the area of the CYSHCN youth in transition population which are continuing to evolve (see below). Most currently available data (CYSHCN survey conducted in 2001) showed that in NM, 5.8% of youths with special health care needs (as reported by their families) receive the services necessary to make transitions to adult life, including adult health care, work, and independence. However, the reliability of this measure is unknown, given the small

numbers available from the survey to assess this issue among youths with special health care needs.

Trends: The results of a study released by the Commonwealth Fund (Collins, 2004) show that (nationally) 13 million young adults between the ages of 19 to 29 lacked health insurance in 2002, as they dropped from their parents' coverage and other sources of insurance for which they may have been eligible. A national survey conducted in 2001 showed, more specifically to New Mexico, that more than 38% of New Mexico CYSHCN youth between the ages of 18-24 reported having NO health care coverage (HRSA/CDC, 2001). This also exists in an environment where the number of quality health care providers statewide is limited, and in the case of some regions and specialties, declining.

Gaps: There has previously been a lack of a statewide, unified infrastructure for the purpose of tracking and oversight of CYSHCN youth in need of transition services. Most of the statewide transition efforts, where available, are done at local levels, using different techniques and standards. Valid performance measures are still lacking.

Disparities: The CYSHCN population seen by Children's Medical Services is additionally compromised in its quest for transition services, as this group is also characterized by living in extreme poverty, and tending to be under-insured or uninsured.

Risk Factors: The CYSHCN population, in need of transition services, as seen by Children's Medical Services tend to comprise a group who are living in poverty, and may tend to be limited by cultural and language barriers.

Positive Influence Factors: The Champions for Progress Grant, the Healthy Transition New Mexico Coordinating Council, the CMS Transition Team, Statewide Transition Coordinating Council,

Evidenced based policies: The Title V CYSHCN Program provides Transition Planning for YSHCN. Public Education Department's Division of Vocational Rehabilitation and Special Education Bureau are addressing their shared aim of ensuring smooth transitions from school to adult life for youth with disabilities through a series of State-wide regional workshops designed to bring together numerous agencies, organizations and family members to address transition mandates. State Department of Education graduation requirements states that local school boards shall ensure that each high school student has the opportunity to receive transition planning.

Evidenced based programs: In the year 2000, Children's Medical Services, through the process of writing a grant proposal for the Healthy and Ready To Work Grant, formed two transition councils. One, the CMS Transition Team, is composed of CMS staff who comprise a cross-section of CMS staff from all four state public health districts. Out of this effort a state-wide transition team was also created. This group, the Healthy Transitions New Mexico Coordinating Council is composed of a much broader state-wide membership base that includes members of the New Mexico Department of Health (DOH), The Department of Vocational Rehabilitation (DVR), the University of New Mexico, the Center for Developmental Disabilities (CDD), Special Education teachers from Santa Fe and Albuquerque, Parents Reaching Out (PRO), Education for Parents of Indian Children With Special Needs (EPICS), and the New Mexico Business Leadership Network. Both councils continue to meet monthly in spite of the fact that they have received no previous funding. Children's Medical Services, and both of the transition councils are now taking the position that transition education and planning need to begin (much earlier) with CYSHCN youth at age 14.

In 2004, Children's Medical Services, as the official Title V, MCH Program for the CYSHCN population in New Mexico, was invited to submit a grant proposal for an incentive award, through the Maternal & Child Health Bureau (MCH) and administered by the Champions for Progress Center, Early Intervention Research Institute, at Utah State University. CMS's proposal was officially funded in late 2004, and the project being created through this modest grant will run through early 2006. Through this project a "train the trainers" type of retreat will be created, a state-of-the-art transition team will

be trained to perform a series of regional transition trainings throughout the state, a prototype transition mentoring program will be instituted, and efforts to create more of an interactive, cooperative state-wide transition infrastructure will begin. It is hoped that a major by-product of this project will be the gathering of more useful transition data that addresses the number of CYSHCN youth receiving transition education and services, types of services, and levels of satisfaction.

Data Sources: SLAITS/CSHCN Survey, The Commonwealth Fund, and HRSA/CDC

SPECIAL POPULATIONS, PART 1: FATHERS AND MALE INVOLVEMENT IN MCH

Fathers are important to family life and to the well being of their children. “An abundance of research in recent years has been definitive in underscoring that fathers have a distinct, necessary and irreplaceable role to play in child development. They bring a uniquely masculine quality to parenting.”^{ix}

From a summary of top ten facts about fathers: Children who live absent their biological fathers experience: at least two to three times more likely to be poor, to use drugs, to experience educational, health, emotional and behavioral problems, to be victims of child abuse, and to engage in criminal behavior than their peers who live with their married, biological (or adoptive) parents. Children who have absent fathers would benefit from close emotional and financial participation of the father who lives outside the home.

From 1960 to 1995, the proportion of children living in single-parent homes tripled, from 9 percent to 27 percent, and the proportion of children living with married parents declined. However, from 1995 to 2000, the proportion of children living in single-parent homes slightly declined, while the proportion of children living with two married parents remained stable. Children with involved, loving fathers are significantly more likely to do well in school, have healthy self-esteem, exhibit empathy and pro-social behavior, and avoid high-risk behaviors such as drug use, truancy, and criminal activity compared to children who have uninvolved fathers^x.

New Mexico Initiatives

- Male Involvement Projects of the Family Planning Program recognize that men’s sexual and reproductive health needs are often overlooked or not accessed. While young men recognize unintended pregnancy, STD-HIV/AIDS as serious problems, experience has shown that drawing them into programs and services requires approaches that focus on their needs.
- The South Valley (of Albuquerque) Male Involvement Project has goals to improve educational and clinical services for men of all ages; reduce risk behaviors that lead to unintended pregnancy, HIV & STDs; and decrease the prevalence of violence, pregnancy and STDs among teens age 15-19 in the South Valley
- For many years the FHB has sponsored the Men’s Wellness Retreat
- The NM Young Fathers Project is a program that helps young fathers under the age of 26. Participants receive individual case management, mentorship and learn life skills in groups with other young fathers. They receive training in parenting, relationship skills and decision making.

Participants learn to navigate systems that impact their families and improve employment outcomes. Some participants are trained to become peer mentors-educators and conduct presentations to other young fathers and community groups.

- NM Young Fathers Project is in 5 communities: Springer, Santa Fe, Albuquerque, Silver city and Las Cruces

An evaluation of key points associated with the question “**Why involve males in reproductive health programs?**” is shown here as an indication of how these needs are also perceived by the New Mexico Family Planning Program team:

- Women have been the principal targets and beneficiaries of family planning and reproductive health programs.
- Failure to incorporate men in reproductive health promotion, prevention, and care has affected their health, the health of women, and the success of the programs.
- Men play an influential role in the reproductive health of their families and sexual partners.
- Men have their own distinct reproductive health needs and demands.
- Inequitable gender relations affect the reproductive health of both sexes.
- Men’s risk behavioral patterns have negative effects on women and children.
- Women want their partners to be more involved and men play dominant roles in decisions
- Men are more interested in family planning than assumed and need communication and services directed specifically to them.
- Couples who talk to each other reach better, healthier decisions and men make decisions that affect both women and men’s health^{xi}. For example, men may choose not wear a condom or be tested for AIDS.

Male involvement was recognized as a critical need for NM during the 2005 needs assessment. A state performance measure was developed, and the situation was critically reviewed:

State Performance Measure 5. The number of male clients acquiring improved knowledge and access to reproductive health care services for men in public health offices through the provision of family planning/reproductive health exams, STD screening and treatment, contraceptives and relevant medical supplies.

The NM Title X Family Planning Program served over 5,000 men in 2004 and is a nationally recognized model for this work with men & reproductive health.

Gaps: Insufficient assumption of male responsibility and male involvement by males in family planning/reproductive health decisions; Traditional view among men, particularly during their teen years that family planning is a woman's issue; Inadequate number of programs that focus on 1) educating men about their roles in family planning/reproductive health decisions; 2) improving their knowledge of and access to male-friendly family planning/reproductive health services; 3) motivating men to focus on their children's future.

Disparities: Adolescent Hispanics as well as other low socio-economic status youth tend to be both less interested in and involved in making family planning/reproductive health decisions, as well as less aware of the educational and clinical services that may be available to them

Risk Factors: Risk factors include being less than 18 years, poverty, poor school performance or dropping out of school, distressed - dysfunctional families and sometimes, cultural mores associated with ethnicity.

Positive Influence Factors: Positive male role models, strong connections to either family and school, and knowledge of and access to male-friendly family planning/reproductive health services.

Healthy People 2010: At present, no Healthy People 2010 Objective exists for this age group and gender, although Objective 9-6, characterized as "Developmental," would measure "Increased male involvement in pregnancy prevention and family planning efforts." Established related Objectives include:

- 9-10: "Increase the proportion of sexually active, unmarried adolescents aged 15 to 17 years who use contraception that both effectively prevents pregnancy and provides barrier protections against diseases;" and
- 9-11: "Increase the proportion of Young Adults Who Have received formal instructions before turning 18 years on reproductive health issues, including all of the following topics: birth control methods, safer sex to prevent HIV, prevention of sexually transmitted diseases and abstinence."

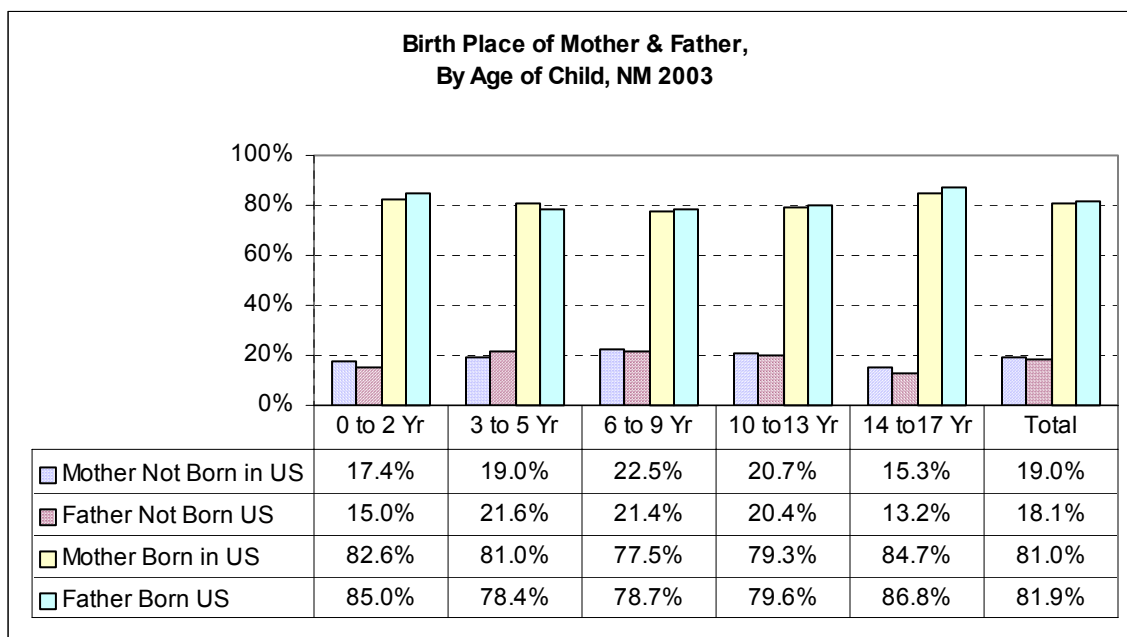
Evidence-based programs: Putting What Works to Work, Emerging Answers, Making the List-National Campaign to Prevent Teen Pregnancy. Counseling and education have a clear scientific basis for their

design. They require a commitment of staff time and effort, as well as additional time from clients; they are tailored to the individual and they include building clients' skills and knowledge.

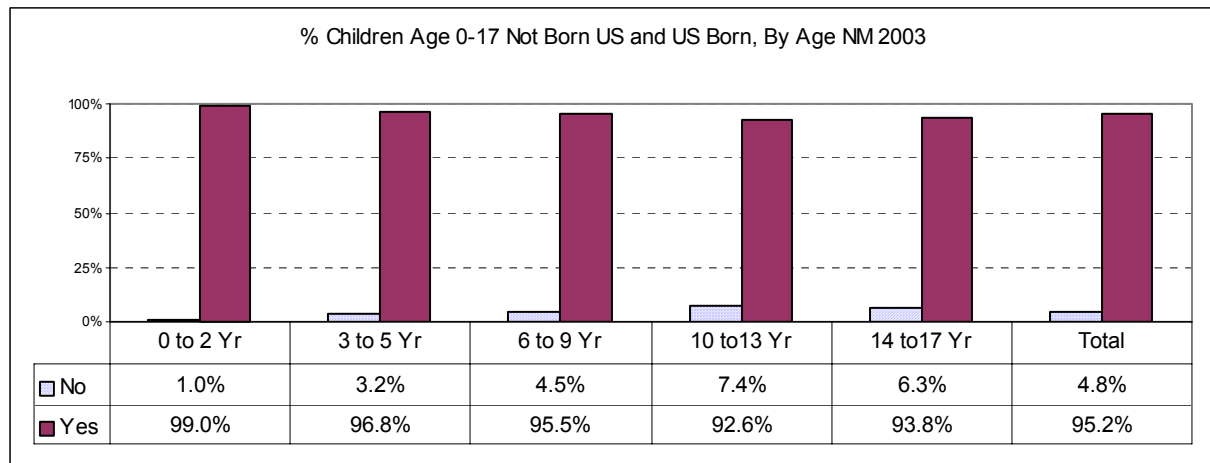
Data Sources: New Mexico (NM) Family Planning Program Quarterly Education Outreach Data Forms and the NM Public Health Division Client Data System “INPHORM.” This is not a population-based measure, but rather an indicator of the state program’s performance. Population-based proxy measures for youth are in the NM Youth Risk Resiliency Survey and for youth age 18-24 & adults in the NM Behavioral Risk Factor Surveillance System. Developmental Objective 9-6 would rely on National Survey on Family Growth (NSFG), which will include data on male fertility in the future.

SPECIAL POPULATIONS- PART 2: IMMIGRANTS AND FATHERS IN MCH IN NEW MEXICO

Immigrants and MCH in New Mexico The NSCH affords the first data to estimate the statewide demographic distribution of the US Born and Not US Born population of mothers, fathers and children. Immigrant families with children face more hardships than the non-immigrant population. As seen in the profile below, there is a need to develop policies that address issues related to poverty such as adequate food, access to primary preventive care and affordable health insurance. In New Mexico, an estimated 18-19% of parents and nearly 5% of children were foreign born.



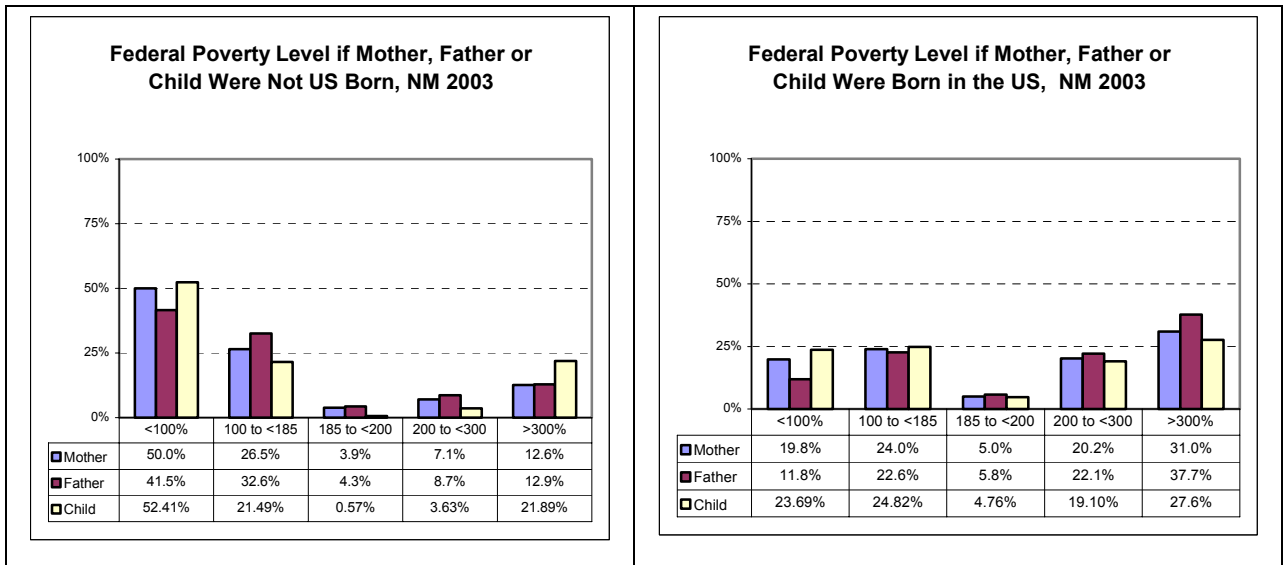
Data Source: Centers for Disease Control & Prevention, National Center for Health Statistics, State & Local Area Integrated Telephone Survey, National Survey of Children's Health, 2003. Analysis by NM MCH Epidemiology



Data Source: Centers for Disease Control & Prevention, National Center for Health Statistics, State & Local Area Integrated Telephone Survey, National Survey of Children's Health, 2003. Analysis by NM MCH Epidemiology

- ❖ 85% of both foreign born mothers and fathers and nearly 80% of foreign-born children age 0-17 were of Hispanic origins
- ❖ 14% of foreign-born mothers and fathers and 20% of children were not Hispanic
- ❖ 23-24% of households of foreign born mothers and fathers and 20% for foreign born children spoke English as the primary language in the home
- ❖ 76-77% households of foreign born mothers and fathers and 79% for foreign born children spoke Spanish as the primary language in the home
- ❖ About 1% of households of foreign born mothers, fathers and children spoke another language in the home. These are largely Asian or European languages.

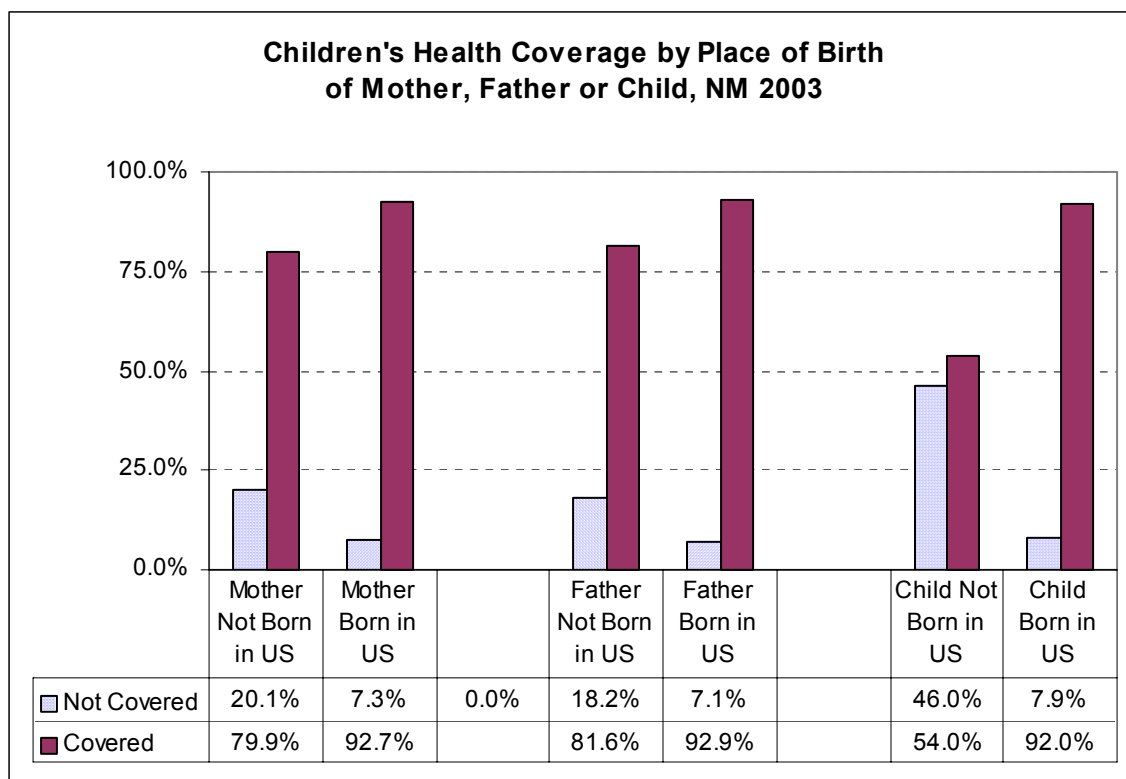
Immigrant Families and Poverty: While households with children 0-17 and with immigrant parents comprised <20% of the population, this population has more than twice the proportion of households below the federal poverty level (FPL) as compared to households of US born parents. Nearly 25% of US born and of immigrant mothers and children lived in households at 100-185% of poverty. Greater proportions of US born households with children were at FPLs 200% and higher.



Data Source: Centers for Disease Control & Prevention, National Center for Health Statistics, State & Local Area Integrated Telephone Survey, National Survey of Children's Health, 2003. Analysis by NM MCH Epidemiology

Immigrants and Health Insurance Coverage: An estimated 18-20% of children of parents not born in the US had no form of health insurance compared to ~7% of children of parents born in the US. Children of foreign born parents had over 2.5 times the risk of having no insurance coverage compared to children of US born parents.

Children not born in the US had much lower coverage: 46% compared to 8% for those born in the US. Foreign born children had 5.8 times the risk of having no insurance coverage compared to children born in the US.



Data Source: Centers for Disease Control & Prevention, National Center for Health Statistics, State & Local Area Integrated Telephone Survey, National Survey of Children's Health, 2003. Analysis by NM MCH Epidemiology

The National Child Health Survey estimated that in 2003 there were 499,992 children age 0-17 in New Mexico. Estimates of the numbers of New Mexican children who did not have health care coverage by birth place of mother, father or child for the table above are:

- ❖ Child not covered, mother not born in US: 19,424
- ❖ Child not covered, mother born in US: 29,471

- ❖ Child not covered, father not born in US: 16,733
- ❖ Child not covered, father born in US: 28,793

- ❖ Child not covered, child not born in US: 11,097
- ❖ Child not covered, child born in US: 37,738

Similarly, estimates of the numbers of New Mexican children who had health care coverage by birth place of mother, father or child for the previous table are:

❖ Child covered, mother not born in US:	77,407
❖ Child covered, mother born in US:	373,689
❖ Child covered, father not born in US:	75,221
❖ Child covered, father born in US:	379,039
❖ Child covered, child not born in US:	13,012
❖ Child covered, child born in US:	437,574

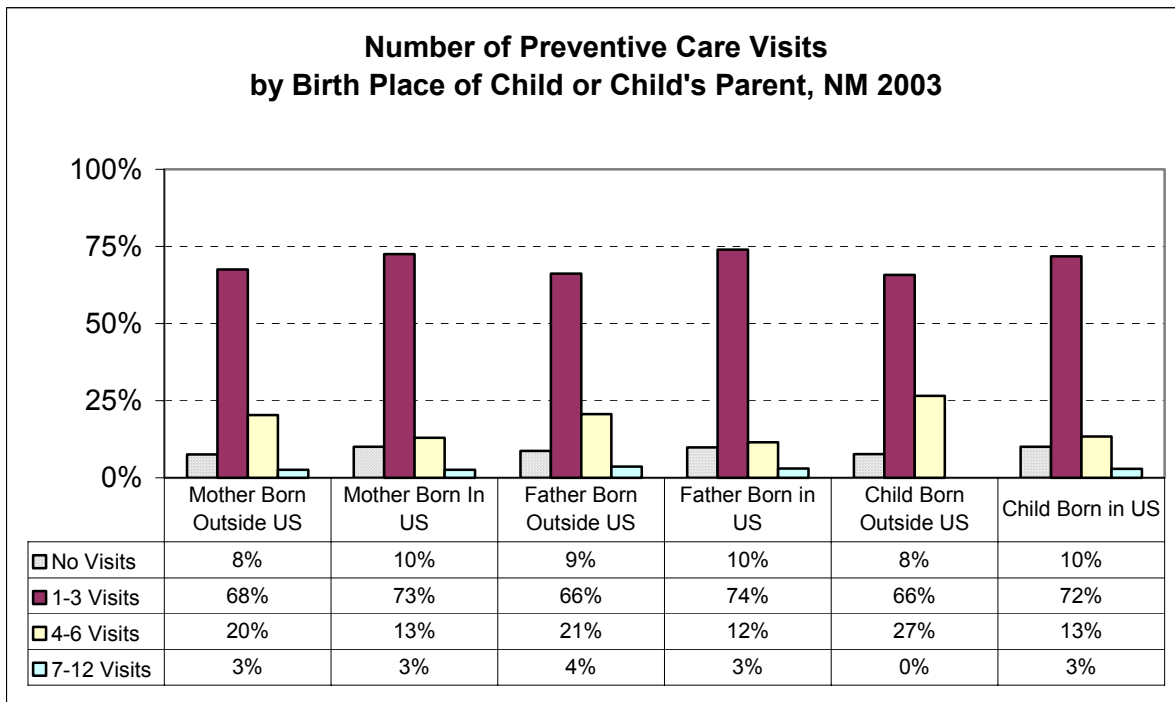
From the 2002 National Survey of American Families, children of immigrants were more than twice as likely to be in fair or poor health or to not have a usual source of health care than children of non-immigrant families.

- ❖ 7% children <6 years if immigrants in fair or poor health
- ❖ 3% children <6 years if non immigrants in fair or poor health
- ❖ 8% children <6 if immigrants were without a usual source of care
- ❖ 3% children <6 years if non-immigrant families without a usual source of care

For children age 6-17, comparing immigrant to non-immigrant, the differences were three fold with 11% of immigrants in fair or poor health and 15% had no usual source of care.

In the next table, the proportion of children who got no preventive care visits during past 12 months appears to be about the same for immigrants or non-immigrants –8-10%. This may represent that portion of the population who are unlikely to use preventive care services, only going when there is an illness or injury.

PREVENTIVE CARE, IMMIGRANT AND NON IMMIGRANT COMPARED:



Data Source: Centers for Disease Control & Prevention, National Center for Health Statistics, State & Local Area Integrated Telephone Survey, National Survey of Children's Health, 2003. Analysis by NM MCH Epidemiology

How does NM compare to the nation? The National Survey of America's Families in 2002 estimated 25% of immigrant families lived at or below poverty, compared to 15% of non-immigrant families.

The high proportion of poverty in NM presents a different profile. The study described issues faced by immigrant families as compared to non-immigrant families in the US*; one can safely assume these issues apply to NM families:

- Family worried about or encountered difficulty affording food, 39% v. 27%;
- Living in crowded housing (over 2 people per bedroom), 27% v. 6%;
- Paying at least half of income for rent or mortgage, 14% v. 6%;
- Problems paying rent, mortgage or utilities, 16-17% for either group;
- Uninsured, 18% v. 7%;
- No usual source of care, 12% v. 4%;
- In fair or poor health, 9% v. 4% (*percentages rounded)

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II.B.4 Examination of the MCH Program Capacity by Pyramid Levels

II.B.4.a Direct Health Care Services

- **Pregnant Women, Mothers and Infants**

Family Planning: 3577 pregnant women were served by Title X supported clinics from 2004 Family Planning Annual Report. The New Mexico Family Planning program provides high quality services for over 40,000 clients in need each year. Some of these services include, Confidential services for teens and adults, including birth control methods and sterilization procedures for men and women. Sexually transmitted disease screening and treatment, counseling on the spread of disease and prevention. Clients are not denied services because of inability to pay. Billing and collection procedures are based on a sufficient proportional incremental scale so that the inability does not pose a barrier to receiving services. Facilities in which services are provided are geographically accessible to the population served and posted hours of operation are convenient to those seeking services.

High Risk Prenatal Fund: **Maternal Health** continues to oversee direct prenatal care services in ten to thirteen local public health offices, while expanding partnerships with private providers to ensure availability of prenatal care to medically indigent women where possible. For high-risk indigent prenatal clients, the program administers a fund for qualified private care providers, on a fee-for -service- basis. The Maternal Health program regulates and licenses the practice of licensed midwives and certified nurse

midwives (CNMs). This oversight ensures a pool of high quality providers of pregnancy-related care providers. Thirteen of the fifteen CNM practices in New Mexico were started in 1997 and rapid expansion continues. There is also a partnership with UNM Hospital to bring prenatal care to urban medical indigents through the Maternal and Infant Care Project. In 2000, over 26% of births in New Mexico were attended by CNM's, and the number of CNM services has more than doubled since 1996. Thirteen of the fifteen CNM practices in New Mexico were started in 1997 and rapid expansion continues. A very successful pilot Provider Agreement with First Choice Community Health, a primary care agency in and around Albuquerque, resulted in 160 women receiving early prenatal care who otherwise would not have gotten prenatal care. There is also a partnership with University of New Mexico Hospital (UNMH) to bring prenatal care to urban medical indigents through the Maternal and Infant Care Project.

Maternity & Infant Care Program:

The Maternity and Infant Care clinics have been providing prenatal care and family planning services for low-income women for over 35 years. The four clinics are placed within community centers in parts of the City of Albuquerque with high concentrations of low-income women. There is also a clinic that serves the New Futures High School student body (pregnant and parenting teens). The clinics are staffed full time by a Nurse Practitioner or Nurse Midwife and support staff. The medical director, a full professor in the Department of Ob-Gyn, serves one clinic session per week per clinical site. A nutritionist and social worker are on staff and circulate between the clinical sites. The staff are able to work with the patients in a culturally sensitive fashion since they are within the patient's community. The University of New Mexico Hospital or the Department of Ob-Gyn covers the employee salaries. These clinics provide the prenatal care for over 25% of the deliveries at the University of New Mexico Hospital. This amounts to over 1000 women per year. Although the M&I clinics provide services to Medicaid and U-Care covered clients, many of these pregnant women do NOT qualify for financial coverage within these programs. Between July 1, 2004 and December 30, 2004, 737 women initiated prenatal care at the M&I clinic sites. Of these, 486 women did not have any insurance and did not qualify for Medicaid funding for their pregnancy

care. At an average cost of \$93.00 per visit and an average of 12 visits per pregnancy this amounts to 1.08 million dollars of clinic visit cost per year. The program continues to receive Title V money to assist with costs but these funds cover only a small portion of the annual operating costs for the Maternity and Infant Care system. The remainder of the costs are currently absorbed by the University Hospital operating budget and the Department of Obstetrics and Gynecology. Both of these organizations have made the ongoing commitment to provide prenatal care to the low-income uncovered pregnant population. The two organizations are confident that by providing prenatal care to this economically high risk group, that they can positively impact on the pregnancy outcome and the improved health of the newborn. For this reason they have continued to financially support the M&I system.

The Families FIRST program assists pregnant women and children with the process of obtaining Medicaid eligibility, assists with obtaining a medical home and follow up with appointments. Assessments for high-risk members are provided and referred to the appropriate resources in their community as well and the Managed Care Organization the member is enrolled in.

Informal meetings with teen parents on early childhood services through the ECCS grant activity are contributing to more understanding about how to meet the needs of this population.

- **Children**

Data from the national immunization survey, NM Medicaid and the NM sample from the NSCH were used to assess access to and use of primary preventive services. See needs assessment sections on these topics.

- **Children & Youth with Special Health Care Needs (CYSHCN)**

Newborn genetic and hearing screening follow-up is provided by the newborn genetic screening nurse and the social workers in the Children's Medical Services Children and Youth with Special Health Care Needs Program (CMS CYSHCN). All children in the state have access to the initial screenings. Although incidence is small, sickle cell

testing, education and outreach are provided through a contract with the Sickle Cell Council. There is concern over the difficulty in following up of patients who have no telephone system; move frequently, frequently have English as a second language or who do not speak English; those who live in a rural area, and, as identified above, infants who are born at home may have difficulty obtaining the genetic and hearing screening that they need. Gaps identified: Lack of adequate clinical and financial support for expanded screening, discontinued services by PHD offices for newborn screening or confirmatory testing for home births, lack of follow-up of clients born outside of New Mexico; lack of a medical home for all clients who need one; need for more education of all physicians regarding the importance of follow-up; need for improved communication between the laboratory and physicians and the CMS CYSHCN Program; need for improvement in the accuracy and completeness of records.

The CMS CYSHCN and UNM multidisciplinary pediatric specialty clinics provide community based assessment and planning that is then coordinated with the primary care physicians. Cleft Palate clinics are essentially volunteer clinics, and although providers travel to many different sites in rural areas, often key providers do not attend consistently because of their own practice limitations. Providers are flown to the rural areas for the specialty clinics. Each year, the CMS CYSHCN Program has experienced increases in the cost of chartering airplanes. The need statewide for each of the types of clinics exceeds the capacity of the pediatric sub-specialty provider community.

Families are at greatest risk for not assessing available services are those lacking knowledge/education, particularly those with cultural language areas and those in rural areas isolated geographically. Continued outreach efforts are needed to educate families about community-based service systems that are available to them and to assist them in accessing those systems.

II.B.4.b Enabling Services

- **Pregnant Women, Mothers and Infants**

II.B.4.b Enabling Services

Although the Medicaid 1115 Family Planning waiver was implemented in the summer of 1998, staffing shortage has hindered progress. District 4 is using temporary employees to help, and District 3 has delayed implementing Medicaid On Site Application Assistance (MOSAA). When nurses implement MOSAA, they lose time needed for clinical services. Staffing shortages also contribute to insufficient publicity about the waiver for both clients and providers. Even when transfer from Title X clinic services to Medicaid is successful, new barriers appear. For instance, when using Medicaid, women may have to drive many miles to a private pharmacy where they may obtain only one month's supply of oral contraceptives at a time, compared with a year's supply from Title X offices. As another barrier to preventing unintended pregnancy, some private pharmacies will not prescribe nor dispense emergency contraceptive pills (ECP) even if the State law permitted pharmacists to prescribe ECP.

Children

- **WIC Program:** The WIC Program safeguards the health of pregnant, breastfeeding and postpartum women, infants and children under five years of age. Household income must be at 185% of the poverty level, and participants must be at nutritional risk. The WIC Program is a preventive program, providing nutritious foods, nutrition education, referrals to health and social services, and improved access to health care in order to reduce nutrition-related health problems during critical periods of growth and development. New Mexico serves 58,775 participants per month. The WIC Program is piloting a WIC Smart card Chip on the food stamps electronic benefits card, which will allow greater flexibility for both clients and grocers. WIC uses client satisfaction surveys; Nutrition Education Survey annually, Food Package Survey. Families FIRST provides and encourages clients to fill out satisfaction surveys, although has not had capacity to analyze these findings.

Children's Medical Services (CMS) has administered the Healthier Kids Fund (HKF) program since 1994, providing preventative and primary care health services to low

income healthy children, and healthy immigrant children, ages 3 to 19, who are not eligible for the Medicaid and SCHIP programs. HKF is entirely funded by the state general fund. Income eligibility is 300% of the poverty (SCHIP is 235%). When SCHIP was implemented in 1998 55% of the HKF clients became eligible for SCHIP. Due to limited funding enrollment HKF has limited enrollment since 1999. Currently enrollment in HKF is a little over 1000 children down from approximately 6,000 before SCHIP. HKF was terminated in 2004 due to budget cuts but reinstated (with no new enrollment) by the Governor due to advocacy by immigrant Mothers. The CMS CYSHCN and HKF Programs have worked closely with the Health Systems Bureau (HSB), which oversees the RPHCA funded clinics that serve as the safety net for uninsured residents of New Mexico. The HSB and the FHB coordinated with the Primary Care Association when the HKF Program was at risk. This liaison continues, with the pilot program for dental case management in Santa Fe.

Commodity Supplemental Food: Program provides supplemental nutritious food to low-income women, infants, children and seniors. USDA donates the commodities. The primary partner is USDA. New Mexico is one of the top three states in the country for food insecurity. NM has applied for more caseload from USDA and has not been granted new caseload for several years.

Farmers Market Nutrition Programs: The FMNP provides fresh fruits and vegetables from farmers' markets to women, infants, and children who are nutritionally at risk and who are participating in the WIC Program. During Farmers' Market season participants receive \$20 worth of coupons to be redeemed at local Farmers' Markets.

There is not a specific program entitled Parenting Education, however, the Child Health Program has always provided parenting materials and training to groups. Child Safety, funded by Title V collaborates with NM Healthy Childcare America at CYFD in New Mexico Safe Kids Coalition. The Office of Injury Prevention in the Injury and Behavioral Epidemiology Bureau of the Dept. of Health takes the lead on all aspects of unintentional childhood injury in collaboration with the Traffic Safety Bureau, the Family Health

Bureau, public health offices, the Children, Youth and Families Dept., and the Dept of Human Services and their respective contractors. Child Safety and its partners target low-income families for the free distribution of child car seats, booster seats, multi-sport helmets, smoke and carbon monoxide detectors, and gunlocks statewide. The Program has a contract with the National SAFE KIDS Campaign to be the sponsor for NM SAFE KIDS Coalition. For the past 15 years, the state coalition has been primarily concentrating on policy issues, assisting this year with the passing of safety equipment and licensing laws for all off road vehicles that will target 50,000 minors under 18 and a booster seat law that will target 130,000 children between the ages of 5 and 12. Currently, the position that usually provides parenting expertise is vacant. There is a great need for parenting education within New Mexico. While the need exists, the only funds directed to this effort exist within the Child Health Program of Title V. Those funds support two FTE's that usually focus on parenting and child health education initiatives. According to a New Mexico WIC Program local survey, 85% of parents receiving WIC services want more guidance in raising their children. Because poor parenting practices are strongly linked with the development of problem behaviors in children, it is important to respond to the expressed need of these at-risk families. Partners are Parents Reaching Out, WIC, Headstart, Early Child Care Program, CYFD, SAFE KIDS. The MCH capacity for parenting education is rather low at this point. To date, the MCH Title V Program has essentially been flat funded since 1997. Rising costs have required budget cuts to maintain direct safety net services.

The Healthy Child Care America New Mexico (HCCNM) continues to be an active intricate part of the New Mexico SAFE KIDS Campaign. The NM SAFE KIDS Campaign and CYFD (HCCNM) developed a partnership to promote safety practices in NM's communities. Title V Child Safety Program staff administer the SAFE KIDS Campaign in New Mexico. This legislative session, efforts targeted children wearing helmets for sports. The Child Safety Program funded by Title V and located in DOH depended on the Healthy Childcare America funding for three years to develop the DOH home safety curriculum, which included all the usual safety issues that SAFE KIDS addresses, a chapter on indoor air quality, and finally an appendix on how to care for your

home without pesticides, plus another appendix listing non-toxic or less toxic alternatives to all common household products that are dangerous to breathe or ingest. It apparently was the first environmental health and safety curriculum of its kind in the US. It has been a success, as CYFD took the curriculum and certified 50 instructors statewide to teach it in the 17 annual RECEC conferences to 8,000 home daycare providers, of which apparently they have already reached some 4,000. SAFE KIDS coalitions and chapters have also used it for their own events. We had previously identified home daycare providers as one of the most at risk environments for children because of the potential number of children in the home. Child Safety Program if Title V is again currently advocating for local SAFE KIDS coordinators to have a presence at the RECEC conferences, teaching a safety course, which was partly even derived from the SAFE KIDS curriculum developed by the national office, as well as having car seat/bicycle clinics and SAFE KIDS booths on site. Child Safety Program is also in the process of soliciting CYFD contractors who do the inspections of home daycares to be members of the Safe Kids local chapters and coalitions.

- **Children & Youth with Special Health Care Needs (CYSHCN)**

The CMS CYSHCN program has faced difficulty in contracting with the family organizations for several years. An effort continues to contract with Parents Reaching Out (PRO), however CMS CYSHCN is unable to access additional resources. The program contract funding has been cut considerably. The program has been able to sustain \$30,000 to contract with family organizations. Last year, the program was unable to get the contract through the contracting process due to changes and reiterations in the process. In FY '06, \$30,000 will go to Educating Parents of Indian Children with Special Needs (EPICS), individual parents, and PRO, should PRO accept a contract. The CMS CYSHCN program realizes that the expectation by some parent organizations is greater contribution by the Title V CYSHCN program, however the program continues to be cut, with and contract funding being especially been hit especially hard as it is general fund connected. Understanding that other states are able to provide more monetary support, NM does not have that capacity. Families are at greatest risk for not assessing available

services are those lacking knowledge/education, particularly those with cultural language areas and those in rural areas isolated geographically.

Regarding medical home, NM is below the national average that reports that families have no problem retaining a referral when needed, and that doctors communicate with other programs. Lack of coordinated comprehensive care and medical home may result in the CYSHCN not receiving all of the care and services needed for optimal growth and development, and may lead to increased morbidity and decreased quality of life. Those at risk for not having care within a medical home may be those lacking financial and other resources. : The program collaborates with Human Service Department/Medical Assistance Division (HSD/MAD) as partners to address quality of care issues such as care coordination, adolescent transition, Medical Home and partners with HSD/MAD and Lovelace SALUD! a managed care organization serving Medicaid clients. The partnerships generate participation in the MCH Collaborative addressing statewide efforts to bring families into medical homes and to educate providers/families about the Medical Home concept. Two major statewide training events were delivered to the staff of the CYSHCN program and parents of CYSHCN attending a Parents Reaching Out Conference. A report on the Medical Home survey of family practice physicians and pediatricians was included in the Epidemiology Newsletter reaching 4,000 organizations and individuals in New Mexico. Steps have been taken to include medical home in the residency-training program for the UNM School of Medicine for pediatrics and family practice. This Medical Home partnership continues to be strong. The Title V CYSHCN Director for CMS serves on the UNM Advisory Board and CMS continues to work with partners in implementing the Medical Home project in five sites in New Mexico. CMS provides the social work component of the medical home team in clinics that are receiving training. In 2005, the CYSHCN Program no longer covers certain ENT diagnoses because of increased medical and pharmaceutical costs and diminishing Federal and State funding. The State continues to experience funding shortages due to the increasing costs of the Medicaid Program. In 2004, Medicaid was reimbursing the CYSHCN Program for care coordination services for CYSHCN fee-for-service clients. The work of the Enchanted Rainbow Children's Care Collaborative continues even

though it is not formally funded. The Collaborative meets quarterly to address issues of care coordination for CYSHCN. The focus is on children birth to age 6 with an emphasis on behavioral health and early referral for developmental screenings for newborns. The collaborative consists of State agencies, parents, Salud Health Maintenance Organizations (HMO's), UNM and early intervention providers. Double Rainbow: As a Part C case management provider in several counties, CMS participated in the Double Rainbow Project in Sandoval County to develop a responsive system of health care with Medicaid MCOs for children eligible for IDEA, Part C.

Transition of Youth with Special Health Care Needs: The Title V CYSHCN Program, CMS, has worked diligently to increase transition services to youth within the program. In the year 2000, Children's Medical Services, through the process of writing a grant proposal for the Healthy and Ready To Work Grant, formed two transition councils. One, the CMS Transition Team, is composed of CMS staff that represent a cross-section of CMS staff from all four state public health districts. Accomplishments of this team include the creation of a Youth Transition Plan used with all clients beginning at age 14. The Transition Plan is a great tool in promoting discussion of transition issues youth may encounter, and planning for these changes. The CMS Transition Team also distributes a quarterly newsletter detailing resources, case studies, and helpful websites geared toward youth in transition. The other Council, the Healthy Transition New Mexico Coordinating Council (HTNMCC) is composed of a much broader state-wide membership base that includes members of the New Mexico Department of Health (DOH), The Department of Vocational Rehabilitation (DVR), the University of New Mexico, the Center for Developmental Disabilities (CDD), Special Education teachers from Santa Fe and Albuquerque, Parents Reaching Out (PRO), Education for Parents of Indian Children With Special Needs (EPICS), and the Continuum of Care Project. The HTNMCC has held two Transition Conferences in New Mexico. The first conference was an overview designed to raise awareness of transition issues, and help participants understand their roles. The second offered more along the lines of "tools" for working with youth in transition. Both councils continue to meet monthly in spite of the fact that they have received no previous funding. Children's Medical Services, and both of the transition

councils are now taking the position that transition education and planning need to begin (much earlier) with CYSHCN youth at age 14.

In 2004, Children's Medical Services, as the official Title V, MCH Program for the CYSHCN population in New Mexico, was invited to submit a grant proposal for an incentive award, through the Maternal & Child Health Bureau (MCH) and administered by the Champions for Progress Center, Early Intervention Research Institute, at Utah State University. CMS's proposal was officially funded in late 2004, and the project being created through this modest grant will run through early 2006. Through this project a "train the trainers" type of retreat will be created, a state-of-the-art transition team will be trained to perform a series of regional transition trainings throughout the state, a prototype transition mentoring program will be instituted, and efforts to create more of an interactive, cooperative state-wide transition infrastructure will begin. It is hoped that a major by-product of this project will be the gathering of more useful transition data that addresses the number of CYSHCN youth receiving transition education and services, types of services, and levels of satisfaction.

In New Mexico there are more than 48,000 adolescents statewide who are recorded as having a chronic medical condition (NM-3CR, 2001). These conditions may vary in complexity and risk from those that would be considered to be relatively minor, to conditions that have the potential to be life threatening (i.e. asthma, seizure disorders, cardiac conditions, various cancers and others). As little as two decades ago, few children with severe illnesses or disabilities survived to adulthood. Today almost 90% of children with chronic conditions live to age 21 and beyond. As this group approaches the ages of 18-21 they begin to lose many of the supports that have provided some degree of stability in their lives and consistency of treatment for their medical conditions. These may include: dropping from their parents medical insurance, losing Medicaid eligibility, or other public insurance programs (i.e. Children's Medical Services), losing the continuity provided by their childhood pediatricians, and support systems that may have been provided through their public school systems. In the year 2000, Children's Medical Services began a series of focused efforts in the area of the CYSHCN youth in transition

population that are continuing to evolve (see below). Most currently available data (CSHCN survey conducted in 2001) showed that in NM, 5.8% of youths with special health care needs (as reported by their families) receive the services necessary to make transitions to adult life, including adult health care, work, and independence. However, the reliability of this measure is unknown, given the small numbers available from the survey to assess this issue among youths with special health care needs.

New Mexico is largely a frontier state and there are many counties that are lacking health care professionals of the same racial ethnic background of the target population. Many of these counties have been designated as Health Professional Shortage Areas. For this reason, the Public Health Division has emphasized cultural sensitivity. The union contract now includes a 10 cent per hour additional pay for translation. Emerging issues are detailed in the Needs Assessment, Part II.3.b. Please refer to that section for complete coverage of those issues.

II.B.4.c Population Based Services

- **Pregnant Women, Mothers and Infants**

II.B.4.c Population Based Services

Family planning services are provided in 51 Public Health Offices and 92 Title X contract sites. There is at least one clinic per county and in larger counties; there are more than 1 LHO to accommodate the target population. The FPP has 6 provider agreements/contracts in District 1 and 5 in District 3, which provide Title X clinical family planning services in 42 different sites in these Districts. Each of the LHOs has agreed to continue dissemination of information to the community and particularly to hard-to-reach populations through collaboration with outside agencies. This includes media, ISD offices, community youth centers, jails, schools, mobile vans and faith communities.

- **Children**

One of the primary activities used to assess population-based services has been Title V's direction of the Early Childhood Comprehensive Systems project. The Early Childhood Action Network is a group of 65 individuals appointed by the Lieutenant Governor to assist the New Mexico Children's Cabinet to develop comprehensive action plans related to five outcomes:

- All children and youth will be physically and mentally healthy
- All children and youth will be safe and supported in their families and communities
- All children and youth will learn the skills they need to support their individual goals

- All children and youth will be able to transition successfully to meaningful and purposeful employment
- All children and youth will be valued contributors and active participants in their communities

The result of the New Mexico Early Childhood Action Agenda process was the development of:

- An early childhood legislative agenda for 2005
- A long term comprehensive early childhood strategic plan addressing all of the Children's Cabinet outcomes and the 5 components of the MCHB state early childhood systems development initiative.
- A New Mexico Report Card to monitor success in improving outcomes

Early Childhood Action Network Meetings were held and the purpose of these networking meetings was to:

- Assure better communication and collaboration by bringing together all of the early childhood planning initiatives currently underway to prevent duplicate of effort.
- Utilize the outcomes and indicator statements developed by the Children's Cabinet as the starting point utilizing the same planning approach (Results Based Accountability).
- Cultivating and informing non-traditional champions
- To deepen the work started by the Children's Cabinet by utilizing the same planning process and getting to action
- To build momentum and a strong and broad constituency to promote and achieve a shared legislative and public early childhood agenda.

The following is the role that the large group of the Early Childhood Action Agenda played:

- To provide input and feedback to the Lt. Gov and Children's Cabinet as the development of the early childhood agenda is created;
- To advise the Lt. Governor and Children's Cabinet on critical and emerging issues facing young children and their families;
- To partner with the Lt. Governor to promote public awareness of the importance of early childhood and to assist in building constituencies to promote the 2005

early childhood legislative agenda as well as the long term strategic early childhood plan.

- To develop a five-year comprehensive early childhood strategic plan to improve alignment of strategies, resources and funding within the early childhood system.

The Role of Early Childhood Action Network Steering Committee: A steering committee was appointed by the Lieutenant Governor to meet on a more frequent basis, every 3 weeks, to process the work done in the large group and flesh it out in greater detail. Membership in the steering committee was about 15 people representative of major early childhood initiatives.

The role of the steering committee was to:

- Develop guiding principles to govern the action planning process
- Prioritize the recommended action agenda items emerging from the large group and based on guiding principles
- Research in more detail specific action items that will be included in the 2005 early childhood legislative agenda
- Align on an on-going basis the work of other early childhood initiatives
- Commission ad hoc groups to work on specific outcomes or early childhood strategies where a pre-existing group does not exist
- Make requests of pre-existing groups to provide more information on specific issues, strategies, best practices

To recommend strategies for reaching out to local level and to families to gain their input and participation in this process The New Mexico Early Childhood Systems plan provides comprehensive strategies for addressing and strengthening the 5 SECCS components to achieve the New Mexico 5 Children's Cabinet outcomes. The strategies contained in the NM SECCS plan are organized into two categories; those that will be the primary responsibility of the SECCS implementation process and those that SECCS process will contribute to, but not take the lead in. The four priorities for which the SECCS process will have the lead over the next three years will be:

1. To improve system of developmental services in New Mexico
2. To implement a streamlined client entry process to measure eligibility for multiple state programs through New Mexico No Wrong Door Initiative

3. To develop a Family Alliance that institutionalizes a mechanism for families to create policy and to have input into policy decisions that affect them
4. To strengthen cross-state agency work at the staff and front line worker level on comprehensive early childhood systems improvements

The priorities that the SECCS process will contribute to will be:

1. Home Visiting
 2. Voluntary Pre-School for Four Year Olds
 3. Strengthen health and safety in child care programs
 4. Provide scholarships through TEACH to increase the number of degreed early childhood educators
 5. Institutionalizing accountability for improving children well-being through New Mexico Children's Cabinet
- To provide input on the public awareness campaign

Planning Framework Method: The State of New Mexico early childhood planning process, initiated by Lieutenant Governor Diane Denish, made use of the Results Based Accountability (RBA) framework developed by the Fiscal Policy Institute of Santa Fe. This framework is fully explained in a planning guide prepared for the Maternal and Child Health Bureau and distributed to all 50 states.⁵ The full framework is also supported by the website: www.raguide.org, an implementation guide sponsored by the Annie E. Casey Foundation and other national and state organizations. The New Mexico Children's Cabinet has derived the outcomes and indicators to address the well being of young children and their families birth to 5 years using this method. By using RBA for the Early Childhood Action Network action planning process, the two processes were aligned and informed each other. Public Engagement in the Planning Process: This was accomplished through use of media, Engagement of Early Childhood Action Network members in outreach to their own constituency groups and Use of Annual Meetings of stakeholders.

⁵ "Results Accountability for a State Early Childhood Comprehensive System: A Planning Guide for Improving the Well-Being of Young Children and Their Families", Mark Friedman, UCLA National Center for Infant and Early Childhood Health Policy, January 2004 (www.healthychild.ucla.edu/Publications Click on National Center for Infant and Early Childhood Health Policy Briefs).

The Families FIRST case management program works collaboratively with two of the three Medicaid contracted MCO's to provide case management to pregnant women and children ages 0-3 years. These services assist women with the process of obtaining Medicaid eligibility, obtaining a medical home, decreasing the utilization of Emergency Room Services which would otherwise be utilized if not medically insured. Assess and educate mothers about prenatal care, assess for Violence, Alcohol, Substance and Tobacco (VAST) use and refer to the appropriate resources. Assess both the pregnant women and children for high-risk service and work collaboratively with the Managed Care Organizations to follow up with these individuals. Assess newborns and children for Ages and Stages, referring children for possible Children with Special Health Care needs. The program has worked with Children Youth and Families Department for early detection and reporting of possible child abuse, and Home visiting services. They work closely with the Human Services Department for services, and enrollment as well as with the Early Periodic Screening Diagnosis and Treatment (EPSDT) program to provide children with the early prevention services available, such as immunizations, and well child screens and referrals.

There is a shortage of dental providers in different areas of the state making referrals for these services more difficult, however the case management assists with obtaining transportation services to dental providers. Title V is collaborating on a pilot dental screening and targeted case management program, using CMS social workers to see persons of all ages in New Mexico and refer them to a source of care. The dental program case manager coordinated intake, assessment of oral health needs, financial eligibility determination and referral services to women, children and their families who were eligible or presumptively eligible for Medicaid or SCHIP or who qualified for oral health treatment services on a sliding fee scale. The case manager actively participated in oral health surveillance activities with the project team.

- **Children & Youth with Special Health Care Needs (CYSHCN)**

CYSHCN: The Title V CMS CYSHCN program grant for Birth Defects Prevention and Surveillance System was approved without funding. The state of New Mexico Title V program is meeting with the Epidemiology Division of DOH to develop a plan to find coverage to reinstate BDPSS.

The Children's Chronic Conditions Registry (3CR) was also discontinued due to lack of funding. This registry is the only registry of children's chronic conditions.

Newborn genetic and hearing screening follow-up is provided by the newborn genetic screening nurse and the social workers in the Children's Medical Services Children and Youth with Special Health Care Needs Program (CMS CYSHCN). All children in the state have access to the initial screenings.

II.B.4.d Infrastructure Building Services

- **Pregnant Women, Mothers and Infants**

The Teen Pregnancy Prevention Action Group (FPP, Abstinence Education, PRAMS, Office of School Health and New Mexico Teen Pregnancy Coalition) is working on projects in Lea County, Rio Arriba County and the South Valley in Albuquerque.

The FPP contracts with seven community based projects to provide evidence based comprehensive sexuality education programs in eight communities.

The FPP funds educational contracts in each of New Mexico's four Districts, primarily for adolescent pregnancy prevention. The educational contracts are:

- Community Wellness Center (CWC) in Taos presents "Girl Time", a primary APP program for 11-14 year-old girls who are not yet sexually active in order to delay the initiation of sexual activity and prevention of pregnancy. This after-school education and enrichment program reaches girls who have risk indicators for adolescent pregnancy.
- La Clinica del Pueblo de Rio Arriba in Tierra Amarilla serves youth at the Chama and Tierra Amarilla Middle Schools by implementing an APP program for 7th and 8th graders using the curriculum *Making a Difference! An Abstinence Based Approach to Prevention of STDs, HIV and Teen Pregnancy*.

- Planned Parenthood of New Mexico in Albuquerque implements *Get Real Get Smart Get Loud*, the APP Program in Ernie Pyle Middle School and Rio Grande High School.
- 21st Century Community Learning Center in Las Vegas implements adolescent pregnancy programming for West Las Vegas School District middle school students using service learning - Teen Outreach Prevention (TOP) curriculum.
- Service Organization for Youth (SOY) in Raton implements, with the assistance of the Health Council, a teen pregnancy prevention program *Reducing the Risk* (RTR) in the Raton Middle School, grade 8. At Raton High School they implement *Safer Choices* programming in the 9th and 10th grade class. At Cimarron High School they implement an after-school service-learning program, *Teenage Outreach Program* for grades 9 – 12.
- La Clinica de Familia (LCDF) in Las Cruces implements an APP program in Dona Ana County for Chaparral Middle School, Gadsden Middle School, and Santa Teresa Middle School using the curriculum *Making a Difference! An Abstinence Based Approach to Prevention of STDs, HIV and Teen Pregnancy*.
- New Mexico Teen Pregnancy Coalition in Albuquerque provides technical assistance to the six educational sites. NMTPC has a conference each year to provide updates on teen pregnancy prevention.
- Judith Seltzer, PhD in Santa Fe provides professional evaluation of the six educational sites assisting with the administering of pre and post-tests to the educational sites, and provides one workshop to the six contract sites to provide assistance of evaluation techniques.
- UNM M & I in Albuquerque provides family planning education including; STDs, violence, alcohol, substance abuse, tobacco use, and male involvement education and services to high-risk populations with limited or no access to School Based Health Centers (SBHC).
- St. Joseph Fertility Care Center in Albuquerque provides health education, counseling, outreach and provision of the Creighton Model Fertility *Care*TM System, including sexuality, and reproductive physiology, education on HIV infection and

AIDS. St. Joseph Fertility Care Center also performs ten eight-hour “The Wonder of Myself” educational classes for a minimum of 20 participants.

- Planned Parenthood of New Mexico provides family planning/reproductive health education in Dona Ana County utilizing the Youth Empowerment Strategies Program. Programming is for 5th-12th grade students at Loma Linda Elementary School, Gadsden Middle School, Gadsden High School and Desert Pride High School.
- The Community Wellness Center provides family planning education services in Taos to adolescents, with the assistance of peer educators. CWC presents the “Draw the Line, Respect the Line” curriculum to a minimum of 250 7th grade school students at Taos Middle School and trains at least two peer educators in topics addressed by the curriculum.
- Counseling Associates, Inc. provides family planning/reproductive health education in Chaves County utilizing “Making a Difference! An Abstinence Based Approach to Prevent STD’s, HIV and Teen Pregnancy.” Programming is for 6th, 7th and 8th graders at Hagerman Middle School.

- **Children**

The Infant Mental Health Collaborative

Committee has met monthly to develop a statewide strategic plan for Infant Mental Health in New Mexico. The Plan was disseminated widely throughout the state. A Request for Proposals was initiated by CYFD to begin implementation of the plan. The collaborative consists of mental health professionals, parents, state agencies, early intervention providers, Medicaid and Salud MCO’s, and UNM all of who are concerned and interested in the promotion of Infant Mental Health in NM. Partners are Communities, Value Options, HSD, CYFD and DOH. The new collaborative, which resembles and MCO for mental health, may be a good change for urban areas, yet hard to administer in rural areas.

Early Learning

The Title V Director has worked with the ECAN network, steering committee, and Children's Cabinet Work Group to promote the concept of preschool for 4 year olds as well as the other early learning objectives developed through this process. The internal MCH capacity for early learning initiatives is limited. To date, the Title V Child Health Manager has worked with Healthy Child Care America on their project. The Healthy Childcare America grant is now terminated. Activities started with HCCANM are being followed through the Safe Kids Coalition. Partners are the Early Learning Community, PED, Safe Kids, and CYFD

Title V Medical Support:

The Medical Director, in his role as a Clinical Assistant Professor of Pediatrics, collaborates with a number of violence prevention related initiatives with UNM Medical school, and local Medical groups and Societies. These include lectures to medical students, Physician assistant, nursing and occupational students on issues of violence, including domestic violence, firearms, and suicide. He is part of a working public health collaborative with the NM Medical Society, and maintains strong ties with the NM Pediatric Society, especially around legislative issues. The Title V Medical Director focuses on issues of family violence. He wrote two books entitled Pathways to Peace and the 2003 report Let Peace Begin With Us: The Problem Of Violence In New Mexico. The latter outlines violence statistics by county; includes resources and highlights of programs that work and continues to be disseminated and used widely throughout the state by both policy makers and non-profits. The Network Coalition against domestic and sexual violence continues to expand its influence and function. The award winning video entitled "Stolen Childhood" has continued to be distributed widely. A legislative memorial study promises to strengthen laws to address domestic violence.

Family Involvement:

The Early Childhood Comprehensive Systems Grant requires family participation and the inclusion of family support issues as one component of the five-pronged systems change grant. One of the overarching objectives of this initiative is policy change through development of a family support initiative. Title V contracted with Parents Reaching Out (PRO) to facilitate the process. The mission of PRO is connecting and empowering New

Mexico families through support, education and information. The intent of the contract is to create support that enables families to participate equitably with a system and will include an effort to prepare the professional community for this partnership. PRO's goals are to help families: decrease stress and isolation; increase their knowledge and use of available resources; enhance the education, understanding, and sensitivity of professionals; and work for positive changes in the systems that affect children.

Although Title V asked PRO to coordinate with Family Support America (FSA) the HRSA contractor, as a collaborator in the overall Early Childhood Comprehensive Systems project, the national contract with Family Support America terminated before they could do so. PRO is to develop a one-day seminar for service programs using Families as Faculty supporting the needs of families and professionals. They are to work with Title V and across departments and service programs when possible to identify families to participate in leadership activities, maintain a toll free number for Family Support activities as described in the grant application, provide stipends to enable families to participate in activities, and provide a two-day seminar that enables families to learn necessary skills to participate equitably with professionals. They will also develop an evaluation for families that participate in activities such as committees, taskforces, meetings or other events to evaluate their experience. In collaboration with Varela Consultants and Title V staff, PRO will plan a Shared Leadership conference that brings family leaders together with professionals and policy makers to develop a family support agenda for New Mexico. Seven meetings have been held with members of Parent Reaching Out and other Family leadership Alliance members to begin the organizing process for the Shared Leadership Conference as well as shape the formation of this new family leadership entity. Family Alliance members were active participants in planning and organizing the Developmental Services Symposium. They kicked off the symposium with their own stories and how state agencies and private providers could have better supported them. New Mexico has also an organized group of community coalitions established under the MCH County Plan Act who have been operating since 1992 to align services for MCH populations in local counties. Representatives of these councils are members of ECAN. Title V staff conducted 2 brainstorming sessions through the County MCH Association to determine their priorities for ECAN work. Their input is included in

the strategic plan. Currently, ECAN is establishing relationships with some of these local community groups to establish pilot sites for testing some of the recommendations emerging from the SECCS planning process.

- **Children & Youth with Special Health Care Needs (CYSHCN)**

Newborn Genetic and Hearing Screening: Need for improved education, communication and support with Midwives providing home births. In rare cases, midwives object to the screening process. The CMS Newborn Genetic Advisory Committee is working diligently with the State Lab, providers and the CMS CYSHCN Program to provide the infrastructure for the expanded genetic screening that was required by recent state legislation. Many of the pediatric sub-specialists are reaching retirement age, are less willing to travel for provision of community-based services; and physician and other medical professions recruitment to New Mexico is difficult because of low wages and rural services.

Undocumented immigrant children are limited in their capacity to travel to needed health care services due to border patrol restrictions of travel. Many children cannot access services within their communities because they are ineligible for services such as vocational rehabilitation, respite care, SSI, SSD. The primary center for rehabilitation and pediatric orthopedic care, Carrie Tingley Hospital, University of New Mexico will provide services only to those clients who have the capacity to pay.

Fear within the undocumented immigrant community, coupled with a poor to negative reception by some agency employees and providers limit access to health care. Speech therapy, occupational therapy, nutrition services, audiology dental and pediatric care are available in larger communities, with only limited to no care in rural areas. For children birth to 3 with or at risk for developmental delay have limited access to services geographically.

A pilot program within the CMS CYSHCN Program is providing case management and referral for dental needs in the Santa Fe area. Efforts are being made to expand this program to statewide referral.

The CMS CYSHCN Program has begun a pilot program to place uninsured immigrant and underinsured children and youth with high cost diagnoses on the New Mexico Medical Insurance Pool high-risk insurance plan. This change increases the capacity of the CMS CYSHCN Program to provide needed care and to meet rising medical costs. This also supports the medical infrastructure because for previously the providers received only up to \$15,000 per child/youth per year and absorbed the extensive unreimbursed costs. With insurance, the coverage is expanded and the reimbursement considerably increased. The reimbursement enables the providers to continue care in New Mexico with expanded medical coverage.

Families are at greatest risk for not assessing available services are those lacking knowledge/education, particularly those with cultural language areas and those in rural areas isolated geographically.

Re: Adequate private and/or public insurance: Although most families reported having adequate private and /or public health insurance, over 40% did not. (SLAITS Survey) Twenty per cent of families did not feel that insurance usually or always meets their child's needs, and about 30% did not feel that costs not covered by insurance are reasonable.

Those most at risk, of course, are those with without insurance, without adequate insurance, and those lacking financial and other resources, as well as those with cultural/language barriers.

Healthy Transition New Mexico is coordinated through the Healthy Transition Coordinating Council and CMS efforts to address medical and psychosocial issues of adolescent transition. The council consists of representatives from DVR, Medicaid, Medicaid HMO/Salud! Programs, CMS, UNM Continuum of Care LEND Program,

UNM Family and Community Partnerships Division of Center for Developmental Disabilities, Parents Reaching Out, and Statewide Transition Initiative Efforts/Participants. The CMS transition team has developed a multi-cultural, bi-lingual transition plan for YSHCN, a model for YSHCN served by other programs.

II.B.4.d-1 Coordination efforts addressing specific groups

The Title V Director has been involved in the development of the Early Childhood Action Network from the start of the process. She was instrumental in the decision to make the Lt. Governor's Office aware of the ECCS grant and to offer the resources the grant provides to develop the Children's Cabinet Early Childhood Agenda. The Title V Director is an appointed member to the New Mexico Children's Cabinet. This relationship has facilitated the collaboration and cooperation of other Departments across the State. She has also served on the Large ECAN group, the ECAN Steering Committee, and the Children's Cabinet Work Group. She has also administered the contracts for the grant. Title V Contractors have been critical catalysts in accomplishment of the ECCS goals and objectives this year. The following are the accomplishments of Title V together with Title V Contractors and the New Mexico community: Early Childhood Report Card, the Early Childhood State Agency Budget, the Short Term Policy Agenda for fiscal year 2006; and a Long Range Strategic Population Level Plan;

The Title V Program under the Department of Health has worked on the Homevisiting Initiative with the Children Youth and Families Department. The two Departments propose to create a partnership between CYFD, DOH and Human Services (three Departments) in implementing both the Newborn Welcome Visit Initiative and follow up services in two counties. DOH programs, Families FIRST and Healthy Families First, Primeros Pasos, may provide 3 levels of voluntary services to Medicaid eligible pregnant and postpartum women through the Newborn Welcome Visit, case management and intensive home visiting in Santa Fe County. Healthy Families First, Primeros Pasos merged with the Families FIRST model and provides prenatal and postpartum visits with varying levels of intensity and need. DOH, Families FIRST will work collaboratively

established programs in Dona Ana Co. to provide welcome visits and intensive home visiting with referrals to Families FIRST for case management/care coordination. Families FIRST case management will assess high risk clients and refer to community resources and follow up services including home visiting services. Combination of home visiting and care coordination serves as a best practice model. The Title V Director, the MCH Epidemiologist, the CMS CSHCN Director, and the FIT Coordinator, as well the Section Manager for Maternal and Child Health all attended the Developmental Screening Forum to design the Strategic Plan for Developmental Screening in New Mexico. In addition, the MCH Epidemiologist compiled the New Mexico data presented at the conference. The Title V Director was on the Planning Committee for the Conference.

The Family Planning Program (FPP), HMO SALUD and the OSH have created a mechanism to bill confidential FP clients through Medicaid. This allows teens to receive confidential family planning services paid by Medicaid. Family involvement is encouraged but for those teens that want their services to remain confidential, this allows access to services without parental notification.

CMS Program: CMS works in close collaboration with all of the state's Human Services Agencies. The local CMS staff are housed in Public Health offices and work closely with public health programs including WIC, immunizations, Family planning, Families First. The CMS staff assists clients in applying for Medicaid and SCHIP through the Medicaid On Site Application Assistance (MOSAA) and Presumptive Eligibility applications, and coordinates with the local Income Support Division (ISD) offices to assure quality client service. The FIT staff has begun to work closely with Children Youth and Families (CYFD) to implement the requirements of the federal Child Abuse Prevention and Treatment Act (CAPTA) legislation where children birth to three years of age with a substantiated case of abuse and neglect must be referred to early intervention. The Healthy Transition New Mexico Coordinating Council is an interagency group including the Division of Vocational Rehab (DVR), Medicaid, and Medicaid HMO/Salud! Programs, CMS, UNM Continuum of Care, the LEND Program, UNM Family and

Community Partnerships Division of Center for Developmental Disabilities, Parents Reaching Out, EPICS, and Family Voices. The CMS Title V CYSHCN statewide program manager is Governor appointed to the Interagency Coordinating Council (ICC), which is the advisory body to the Family Infant Toddler (FIT) program, which is the state Part C program under IDEA. The Council is made up of representatives from Medicaid, CYFD, the Public Education Department, the Public Insurance Commission, the medical society, local early intervention providers, UNM and families. The MCH Collaborative and the Enchanted Rainbow both of which CMS is a member of meet quarterly to address statewide issues related to CYSHCN in collaboration with Medicaid and the Medicaid HMO/Salud! programs and other partners. The Title V CYSHCN Director is member of the Early Childhood Comprehensive Services Advisory Board. The HSD Alphabet Soup group consists of leadership of Medicaid, Medicaid Salud! Programs, HMO's, DOH, and CYFD and meets regularly to discuss child health policy issues. Providing services and multidisciplinary clinics statewide, the Title V program connects with over 900 medical providers and all community social service agencies and state agencies. The CMS FIT program receives funding from the Long Term Services Division of DOH who administers the Part C program. This funding supports 12 social workers, a Coordinator and 6 clerical positions to ensure access to early intervention services and service coordination. The Coordinator provides training for FIT staff and early intervention programs regarding provision of service coordination and federal statute compliance. The Title V Director meets weekly in Leadership Team meetings with the WIC Director, the Office of School Health, the Behavioral Health Coordinator and the Infectious Disease Bureau Chief (AIDs Program Direction). Weekly progress on the Departmental priorities of Teen Pregnancy, Behavioral Health and Obesity are standing agenda items. Much progress has been made with these collaborative meetings. The Title V Director is the supervisor for the SSDI administrator.

II.B.4.d-2 Other groups of major providers for the MCH population

CMS: The two Tertiary Care Medical facilities in the state, the U. of New Mexico Health Sciences Center and Presbyterian Hospital in Albuquerque, provide specialty and

subspecialty care and each has Level III perinatal facilities. The Department of Health assists in training of U.of NM School of Medicine students and residents in their rotations through select health department clinics. Both hospitals provide specialists and sub specialists providers for the DOH Title V CYSHCN Children's Medical Services (CMS) cleft palate outreach clinics throughout the state. UNMH provides pediatric specialist providers in collaboration with CMS to provide 128 pediatric specialty outreach clinics a year around the state. Clinics provided include asthma, cleft palate, neurology, metabolic, endocrine, genetics, nephrology UNMH pediatric sub specialists in metabolism and genetics are contracted to consult with the State Laboratory and CMS on CMS's Newborn Genetic Screening Follow-up Program. UNMH provides the PALS physician hotline, which provides immediate specialty consultation to physicians in the DOH and other state agencies. Specialty Departments at UNMH and other UNMH facilities provide information, consultation and collaboration on various DOH and other state projects. CMS Children and Youth with Special Health Care Needs (CYSHCN) program cares for children with complex medical problems and these children often require care at a tertiary care center or by tertiary care specialty clinics. The SECCS grant has improved the connections with Parents Reaching Out and NM Family Voices.

II.B.4.d-3 State discussion of CYSHCN Constructs of Service System

The New Mexico Title V CYSHCN program, Children's Medical Services (CMS) collaborates with partners statewide. With limited resources, CMS has maximized its capacity to ensure an effective system of statewide services to CYSHCN.

State Program Collaboration: This program collaborates with and receives funding from the State Laboratory Division in the provision of Newborn Genetic Screening; works with the School for the Deaf, Step Hi Program to ensure newborn hearing screening and follow-up; UNM Metabolic Consultants for genetic follow-up; CASA, TUPAC, WIC, the ARC and UNM Hospital OB GYN Department for the Birth Defects Registry and Neural Tube Defect surveillance and prevention; and the Health Systems Bureau for networking with the RPHCA funded centers. The New Mexico Sickle Cell Council provides counseling, screening and follow-up for sickle cell and other hemoglobinopathies; and educational outreach to clients and providers. This program

partners with the Navajo Nation in education regarding use of folic acid to prevent birth defects.

State Program Support for Communities: CMS provides medical coverage and care coordination for CYSHCN meeting the program's medical and fiscal eligibility guidelines. In addition, CYSHCN with medical diagnoses who are covered by Medicaid/SCHIP and other insurance receive clinic services in multidisciplinary pediatric specialty outreach clinics, and care coordination by CMS social workers. The clinics are staffed with local providers along with specialists from the University of New Mexico.

Children birth to 3 with complex medical diagnoses who enter through the CMS Family, Infant Toddler Program are transitioned to CMS CYSHCN social workers when they reach the age of 3. This assures ongoing medical management support and coordination of care.

Coordination with Health Components of Community Based Systems: With a CMS network of 60 social workers located and co-located with other health services in New Mexico, coordinating health care for CMS CYSHCN statewide. In this capacity, together with community councils and services, CMS works with the Title XVIII Medicaid and Title XXI SCHIP program - largest providers of medical care - in effort to provide and model family centered, community based, culturally competent coordinated care. The efforts of the Title V CYSHCN Program resulted in the integration of purchasing specifications for CYSHCN in the Medicaid/SCHIP RFP and subsequent contracts (FY '01). These specifications assured a MCH definition and identification of CYSHCN; a requirement to provide care coordination (MCH definition) services and recommendation the MCO's allows specialty providers to be the primary care physician per family request. Care coordination includes cultural competence and family partnership in decision-making. The new RFP is being written and this Title V program has been assured that this special needs purchasing specification section has not only been continued, but will now include adults with special health care needs. The new language in the RFP is 'individuals with special health care needs.' The social workers statewide provide oversight and care coordination for infants identified through the Newborn Genetic Screening and Newborn Hearing Screening programs. These programs

are mandated under state statute. These programs provide a statewide system of screening, prevention and identification of infants with genetic and metabolic disorders and hearing loss. The care coordination provided by CMS social workers ensures that infants identified with a disorder are receiving a continuum of care. HB 479 was passed in the 2005 legislation that will require expanded screening for all newborns born in the state of New Mexico, expanded screening from a current 6 to 27. CMS will be working with the State Lab, genetic advisory committee Pediatric advisory board in strengthening the follow-up. After initial care for the first 3 years under the Family Infant Toddler Program, children are transferred to CYSHCN social workers to continue care coordination so long as it is needed.

Coordination of Health Services with Other Services at Community Level:
Healthy Transition New Mexico is coordinated through the Healthy Transition Coordinating Council and CMS efforts to address medical and psychosocial issues of adolescent transition. The council consists of representatives from DVR, Medicaid, and Medicaid HMO/Salud! Programs, CMS, UNM Continuum of Care LEND Program, UNM Family and Community Partnerships Division of Center for Developmental Disabilities, Parents Reaching Out, and Statewide Transition Initiative Efforts/Participants. The CMS transition team has developed a multi-cultural, bi-lingual transition plan for YSHCN, a model for YSHCN served by other programs. With a CMS network of 60 social workers located and co-located with other health services in New Mexico, social worker coordinate health care for CYSHCN working with all community services impacting CYSHCN. Social workers have a first hand working knowledge of CYFD – protective services, Food Stamps, ISD, community organizations providing services to multicultural populations, i.e. Somos Un Pueblos Unidos, local and statewide family organizations, school systems, some faith based service organizations such as Catholic Charities, Lutheran Social Services, and community domestic violence and substance abuse coalitions. Agencies and programs receiving Title V Maternal and Child Health Funding participate in a MCH Collaborative addressing transition, medical home and other MCH initiatives. Enchanted Rainbow continues the work of Double Rainbow with statewide representation – with a focus on children birth to 5, autism, immigrant health, and infant

mental health. A newly established Behavioral Services Collaboration began with a focus on mental health and may extend to other health and community services in terms of regionalizing resources and services in New Mexico.

The Title V Program works with Parents Reaching Out, EPICS and Family Voices to assure critical family involvement in decision making and training of providers and families, collaboration regarding transition of CYSHCN, cultural competence issues and ongoing efforts in the state to create a medical home climate. Work continues with these partners on the Family Infant Toddler Interagency Coordinating Council, the MCH Collaborative and the Healthy Transition New Mexico Coordinating Council. This coordinated effort increases the capacity of the Title V CYSHCN program to meet the MCH model and to increase the participation of key players in addressing MCH initiatives.

II.B.4.d-4 Standards, Guidelines, Program Monitoring, Evaluation

The CMS CYSHCN management team participates in the planning and evaluation of the delivery of services to CYSHCN. With a Statewide Program Manager who is a social worker and 4 District Program Managers who are social workers, as well as 12 Social Work Supervisors, the 52 social workers in the CYSHCN program receive ongoing supervision and evaluation of their job performance. A FIT Coordinator is a statewide consultant/supervisor assisting district supervisors in assuring federal statute compliance and job performance evaluation.

The CMS program has begun to work in collaboration with the Family Health Bureau MCH Epidemiology program to improve its data analysis of the newborn hearing screening program and other health indicators especially as reported in the SLAITS survey. Supervisors evaluate their services in an ongoing fashion, with a computer program that assists them in monitoring caseload size.

The Maternal Health Program Manager licenses all nurse midwives in the State. Almost one FTE is devoted to this effort to assure quality of those services. The Family Planning

and CYSCHN Program Managers are members of the Council on Performance Excellence, a continuous quality improvement initiative within the Department. Recent improvements have been the DOH intranet service. Please refer to the Pyramid of State Examples in the Appendices.

II.B.5 Selection of State Priority Needs

II.C Needs Assessment Summary

The Title V Program uses a system approach that begins with a needs assessment and identification of priorities. It is expected the process will culminate in improved health outcomes for the target population. In 2005, the State agency conducted a comprehensive needs assessment to identify state MCH priorities. The State then developed state performance measures to monitor the success of their efforts to arrange programmatic and policy activity around these priorities. The needs assessment was population-based and community-focused. The assessment issues were organized into three categories: 1) A review of selected Title V MCH specific performance measures and health indicators by population group, seeking input on what factors needed to be addressed to improve overall performance on the indicators and to address known gaps, disparities or barriers or build on strengths, 2) A review of access to and use of recommended primary, preventive and specialty care. Children with special health care needs were one focus of access to specialty care. The assessment was organized around 3 MCH populations: maternal and infant health in terms of women's health in pre-conceptional, prenatal and post-partum periods AND infant health; child health ages 0-14, and youth health ages 15-21. This section of the assessment included the dimensions of community-based systems and the network of partnerships. In addition there were 2 topics representing cross cutting concerns: fathers and families; and MCH issues regarding immigrants. The assessment was data-driven. The MCH Epidemiologist, Susan Nalder, compiled a data book using many various sources of population based data, program and selected studies or review of literature. This extensive data collection effort, resulted in the provisional NM MCH Data Book. The State reviewed the data at the State Agency level. Instead of assessing all of MCH, the State chose to assess certain

aspects of MCH that were particularly troublesome for New Mexico. Using the pyramid process of prioritization and a review of the State's performance during the last 5 years, a group of State-level Program Managers and the Medical Director chose a list of 10 priorities as a framework of the assessment. To include the community and other stakeholders in the process of the development of state performance measures, the State MCH Program Managers then organized a series of town meetings in the four quadrants of the state. The assessment took place in four public health district sites in March 2005: Santa Fe, Albuquerque, Roswell and Las Cruces. Stakeholders invited included other state agencies, sister programs within the MCH state agency, county health offices, providers and facilities serving MCH populations, professional organizations, community-based and advocacy organizations, and the public.

Each facilitated assessment exercise lasted 7 hours with 2 hours for formal presentations by FHB staff and 5 hours for soliciting input. The assessment focused on ten health topics. Each topic could become a state performance measure if the assessment indicated the need. Conclusions of the assessment were used to finalize the priority needs. While several of the State performance measures were maintained, some were traded for new measures focusing on identified needs. . Conclusions of the assessment were used to finalize the priority needs. While several of the State performance measures were maintained, some were traded for new measures focusing on identified needs. The priority health status problems of the MCH and CYSHCN populations are attributed largely to problems associated with poverty, working families with too few resources, no universal health coverage and its related issues of access to/use of primary care, health risk behaviors associated with stresses of poverty, and a high proportion of the state's counties not having health counseling for those who have problems with substance abuse. The assessment concluded that unemployment increased and the overall poverty performance did not improve. The assessment indicated that health gaps and disparities are seen consistently among teens, parents with only a high school education or less, and single parents. These characteristics translate into greater proportions of health risk behaviors, and lower access to and use of primary preventive care or specialty care. Although the state made progress in reducing the proportion of the population that has no health insurance, critical gaps persist. There is a significant challenge in assuring access

to care for the working poor and immigrant families. Male involvement was recognized as a critical factor in the health of children. While the infant mortality rate, the neonatal and post neonatal mortality rate remained lower than the national rate, disparities were also still observed. An estimated 30% of new mothers had positive behaviors with respect to the factors in the Healthy Birth Index, which indicated the need to raise prenatal health to a state priority. Home visiting and preconception health education were suggested as evidence based strategies. Some strengths identified were that more children received Medicaid services although, the risk of gaps in coverage may have increased. Medicaid has made significant progress, increasing the number of children served by increasing the reimbursement schedule and recruiting additional dentists who would accept Medicaid. The number of women receiving dental services during pregnancy was maintained in 2004. Challenges remain first trimester prenatal care as New Mexico, lagging behind the U.S. at twice the percent for beginning, inadequate use, childhood overweight, and hunger. Twelve percent of parents surveyed indicated their children were not always safe at home and fifty percent weren't safe in their neighborhood. The number of reported domestic violence cases and the number reported with children at the scene increased from 1999-2003. Unintentional injury caused almost half the deaths in children and youth 1-24 yrs.

II.C.1 List State Priority Needs

The following state performance measures were carried over from the previous years or added on for this year:

1. The number of 33 counties adopting 6 criteria of the conceptual framework of Healthy Youth-Healthy Communities through an Assets-Resiliency model approach when working with youth. Revised measure with 6 criteria for monitoring and reporting progress,
2. Percent of first newborns and mothers receiving community home visiting services. Revised measure; previous measure was general and attempted to capture more information than could be reported. Revised measure will use PRAMS to monitor.

3. Reduce unintended pregnancy to less than 30% in mothers who have a live birth. Previous measure; continues for period through 2009.
4. The percent of mothers who achieve all criteria of the Healthy Birth Index: new measure, data will come from PRAMS
5. Male involvement
6. Reduce oversight and obesity in high school youth, from NM YRRS. Revised previous measure that reported on children 0-5 years from NM WIC program.
7. Reduce the number of children witnessing violence (exposed to domestic or sexual violence) as expressed by the percent of children present at a domestic violence scene.
8. Reduce the proportion of new mothers who report being physically abused during pregnancy.

II.C.2 Summary of Process Used/New Processes Used

The Title V Programs studied the data from the Title V Performance Measures, the DOH Strategic Plan, and the new NM MCH Data Book and as well as the information obtained in the needs assessment to develop the priorities of the State for the next 5 years. The Title V staff also analyzed the capacity and resource capability of the Title V Program. Program expenditures for over the last 8 years were analyzed to note funding trends, how funds were spent within the framework of the MCH Pyramid and whether the funding was appropriately distributed to meet the needs identified in the assessment. The MCH management team brainstormed about the solutions to be implemented where possible, given current funding realities. Funding for the program had not been increased significantly for 8 years. Resources were scarce and reallocation of resources was difficult at this time, however, a map for action was determined for future funding opportunities and grants. The three priority areas that the Family Health Bureau is focusing on are: Promoting healthy families, 2) Promoting births to healthy families and 3) working to affect a reduction of violence in families.

In promoting healthy families :

1. Increasing the access to and use of health care:
 Reduce barriers and disparities to accessing community-based health and health related services for women, children and youth. E/I

- Reduce medical services funding gaps for children in NM, i.e. children who are non-Medicaid eligible, children with orthopedic/rehabilitative needs, and children in need of catastrophic medical funding such as organ transplants. I/E
2. Promote youth development strategies to reduce the incidence of substance abuse and mental health disorders and other high-risk behaviors in youth under age 21
EI
 3. Increasing male involvement in the family and increasing the quality of Fatherhood;
Expand male involvement programs in state I/E
Expand primary prevention home visiting services to teen parents and first-time parents statewide. E
 4. Decreasing the teen chlamydia rate
Expand funding for chlamydia treatment D
 5. Promoting healthy weight among parents and their children.
Expand parent education of healthy feeding relationships D
Change school nutrition environment, i.e. competitive foods I
Expand nutrition intervention for overweight and obese children D
 6. Establish an infrastructure to support and monitor transition services for adolescents with special health care needs. I

To increase births to healthy families:

7. Working with women on preconceptional health issues such as increasing folic acid supplementation, while reducing smoking and drinking:/E/I/D
8. Increase the proportion of women receiving adequate prenatal care. E/I/PB/D
 9. Decreasing the number of women abused in pregnancy
Monitor confirmed cases of abuse of pregnant women PB

To affect a reduction of violence in families:

10. Monitor confirmed cases of child abuse/neglect; confirmed cases of abuse, neglect and exploitation among adults; domestic violence:
11. Reduce fatal and non-fatal family violence. PB

12. Measuring of substance abuse in families with children.
13. Promote child safety by focusing on reduction of unintentional injury.

All of these priorities are in sync with the Department's priorities of reducing teen pregnancy, improving the weight of adults and children, improving access to medical and dental health services in agency-funded primary care centers, improving access to WIC, Family Planning, Families FIRST, and Children's Medical Services, increasing the number of primary health care and emergency medical professionals supported or obligated per year and working in underserved areas, reducing the percentage of Medical and Dental provider positions vacant over 6 months in community-based health centers, increasing the number of children screened for sealants by the DOH sealant program, and improving access for school age children by implementation of 34 new school based health centers .

Priorities List vs. Title V Capacity and Resource Allocation

Increasing the access to and use of health care:

Access to health care involves Title V serving on the EPSDT Steering Committee; working to improve developmental screening of children; promoting immunizations, and case management to use scarce resources well. Data indicates that as children grow older, their well child visits decline and physicians do not do developmental screening as they should. Lack of funding does not mean that Title V cannot work to affect change. Direct Services that need expansion are chlamydia treatment, prenatal care, nutrition interventions around obesity such as counseling for children at risk of overweight or obesity. Enabling services needing focus include: access to community-based health and health related services for women, children and youth; reduction of medical services funding gaps for children in NM, Youth development, male involvement, prenatal care and parent education. Infrastructure services should focus on community based services development for populations that experience health disparities, including male involvement, and mental health. Population based services should focus on: a method to monitor and track confirmed cases of abuse of pregnant women as well as methods to reduce family violence. The annual budget is increasingly spent on provision of direct

services to the MCH population. The list of priorities, while it is imperative that we provide new services such as these, the MCH budget has not increased significantly since 1997. An effort will be made to restructure the MCAF Section to focus on the priorities above for expansion of home visiting, male involvement through Family Planning, and Youth development strategies. As a new Medical Director will be hired this year, the emphasis on violence reduction will be a primary emphasis for that position. Resources for prenatal care, coordination with the WIC Program can change resources to focus on the folic acid component of prenatal care and an emphasis on reduction of smoking and drinking among women of childbearing age. Each of the priorities above ties to a State Performance Measure for New Mexico.

New State Performance Measures will be monitored closely to see if they indicate any changes in the prevalence of these issues. If these steps are taken, the hope will be that the level of low birth weight in the State will be reduced as will perinatal, infant, neonatal, post neonatal, and child morbidity and mortality.

II.C.3 Summary Needs Assessment Partnerships & Selection of Priorities

The partnerships developed during the past year, while the assessment has taken place, will be invaluable for future collaborations. They contributed to the selection of Priorities as all participants of the local workshops were asked if any other priorities existed for them. The chosen state performance measures had the support of all four districts and local partners.

II.C.4 Brief Justification of Data-Driven Prioritization Process

The process was most certainly data driven as the MCH Epidemiologist's production of the new "New Mexico Maternal Child Health Data Book" helped to drive the process by exposing all participants to the critical data for MCH. Data was researched and graphs prepared; a literature review conducted for new topics (Immigrants and MCH, Male Involvement and Fatherhood). Program managers, epidemiologists and other staff contributed material, including material taken from the performance measure reviews described above. These welcome books with errata sheets were given to all participants in the district MCH Needs Assessment workshops as a reference and base for discussion around the priority topics/indicators. The data did not intimidate or discourage

participants in the statewide assessment exercise, largely because the items in the data book constitute a shared agenda throughout the state.

II.D Health Status Indicators

Each of these indicators was examined in detail and is found in the assessment of the population, Part II, B.# of this assessment. The Title V MCH program recognizes it needs to address many factors that are associated with poor infant outcomes; the state measures on healthy birth index and intention of pregnancy will focus attention on birth weight issues as well as infant mortality; as cited in the needs assessment, development of home visiting programs could be highly instrumental in reducing fatal and on-fatal injuries in children. Title V MCH sponsors a position for childhood injury prevention in the Injury Prevention Unit; and the program works closely with the initiatives of the Injury Prevention group where resources are centered to address the fatal and non-fatal injury measures. The FHB (with leadership from Victor La Cerva, the Title V MCH Medical Director) continues to distribute two of its award winning videos, Man to Man (for use in any context of working with young men) and Stolen Childhood (which educates about the adverse impact on children of exposure to domestic violence). Both are now being replicated in DVD format, along with their study guides. The Network Coalition is a collaborative effort with IPEMS, and a CDC funded grant to address both sexual and domestic violence, that continues to offer informational cross training sessions, legislative advocacy and the development of position papers with recommendations for action. In addition, there is a newly formed work group to address the issues of boys in the Santa Fe area, with statewide implications. The FHB program took an active role this last legislative session, analyzing many violence related bills, and the Medical Director, at the request of a Senator, wrote and got passed a memorial to assess the issue of children and domestic violence.

The Title V Administrator works at the leadership level to promote this work as well.

II.E Outcome Measures – Federal and State

Each of these indicators was examined in some detail and is found in the assessment of the MCH population. As with the health status indicators, the new state measures on

Healthy Birth Index, intention of pregnancy, and abuse during pregnancy will help to focus state efforts that can impact infant mortality. The majority of infant deaths are due to short gestation and birth defects. It will be critical for NM to strengthen state performance on prenatal care, maternal smoking and drinking, use of folic acid, and to continue its work on birth defects prevention – beginning in the pre-conceptional period.

01 Infant mortality rate per 1,000 live births

02 Ratio of black infant mortality rate to white infant mortality rate

03 Neonatal mortality rate per 1,000 live births

04 Post Neonatal mortality rate per 1,000 live births

05 Perinatal mortality rate per 1,000 live births plus fetal deaths

06 Child death rate per 100,000 children age 1-14

State Outcome measures = none at this time

1. Title V MCH Block Grant, Comprehensive Assessment, Working Groups

Preconceptional Health, Family Planning, Maternal & Infant Health

Roberta Moore: Maternal Health Program Manager, 476-8908

Lynn Mundt, Family Planning Program Manager, 476-8876

Sharon Giles Pullen, WIC-Breastfeeding, 476-8812

Eirian Coronado, PRAMS Epi-Coordinator, MCH Epi Program 476-8895

Susan Morgan, Family Planning Nurse, 476-8972

*Emelda Martinez: Families FIRST Program Manager, 476-8938

Children age 1-12 Years

Emelda Martinez,: Families FIRST Program Manager, 476-8938

Rick Vigil, MCAF-Youth Development, 476-8962

Victor LaCerva, FHB Medical Director, 476-8904

Jane Peacock, FHB Chief, 476-8901

Youth Age 13-19 (some to age 24)

Gloria Bonner, Abstinence Program, 476-8998

Wanicha Coggins, Family Planning Medical Director, 476-8870

Karen White, Youth Development, 476-8906

Lynn Christiansen, CMS Program Manager, 476-8851

Ann Do, CDC-PMR MCH Epidemiology Resident, MCH Epi Program, 476-8894

Children & Youth with Special Health Care Needs

Lynn Christiansen, CMS Program Manager, 476-8851

Mopsy Matthews, CMS Medical Director, 476-8854

Ann Do, CDC-PMR MCH Epidemiology Resident, MCH Epi Program, 476-8894

Immigrants

Jane Peacock, FHB Chief, 476-8901

Roberta Moore: Maternal Health Program Manager, 476-8908

Eirian Coronado, PRAMS Epi-Coordinator, MCH Epi Program 476-8895

Lynn Christiansen, CMS Program Manager, 476-8851

Mopsy Matthews, CMS Medical Director, 476-8854

Fathers

Susan Lovett, Family Planning Program,

Victor LaCerva, FHB Medical Director, 476-8904

Section II. MCH Needs Assessment
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II.B.4 Examination of the MCH Program Capacity by Pyramid Levels

Summary of MCH Needs Assessment

New Mexico is large geographically and diverse culturally and economically. The issues and needs of the state's MCH health program are similarly diverse based on the MCH District Needs Assessment workshops held in each of the four health districts early 2005. There were also many commonalities that emerged during the Needs Assessment process. A common theme in the districts was need for greater emphasis on prevention and education for families, teens, and current and potential mothers and fathers.

Health professionals and advocates from the NM public health service and partner agencies see access to health care (both primary and specialized) for low-income, immigrant, and teen populations as significant issues. They expressed the need for system-wide solutions. Obstacles and barriers that limit the effectiveness and efficiency of service delivery are similar across the four health districts. They include a lack of indigent funds, inconsistent eligibility requirements for indigent funds, and insufficient funds for the statewide Healthy Kids program. Other barriers are Medicaid requirements (e.g. the six month re-certification and eligibility and service limitations); variations in co-pays at primary care centers; and cultural, language and transportation issues.

The state's public health system of the Public Health Division and its community outreach is a great strength of service provision for the MCH population. Public health staff and many MCH community partners actively participate in assessing needs, community planning, and action through community/county health councils (and MCH Councils) and numerous state and local coalitions that address MCH-related health issues. Many state and local policies have been implemented that benefit the MCH population. The 2005 session of the NM State legislature approved the establishment of additional school-based health centers, adopted regulations on competitive foods in schools, and revised a state law that requires now children up to age seven to wear seat belts.

Substance abuse and violence are pervasive and affect all population groups. Substance abuse is an underlying cause of many health, social, and economic problems that especially impact the MCH population.

The needs of the teen population were another common theme. All districts noted growing number of exciting, creative programs and services for youth. In addition, the needs of the teen population are many and include: more support for

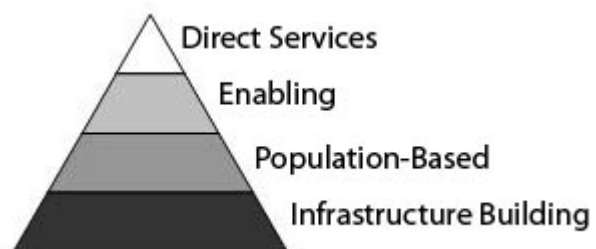
comprehensive sexuality education; better access to services; greater availability of appropriate education and activities to build youth self-esteem and skills; more active involvement of males and father in education and prevention programs, and greater Involvement of youth with special health care needs in planning for their transition to adulthood.

Overall a picture of a vital system of statewide and community services and programs emerged with greater focus on prevention and collaboration. Many needs exist but the will and ability to address these issues are clearly present.

Introduction

This section of the Needs Assessment examines MCH program capacity and related recommendations for service improvement by the Title V pyramid levels, shown in the figure below.

MCH Title V Pyramid Levels



The sources of data for this section are the Needs Assessment workshops held in each of the four NM health districts in March and April 2005. (See also Section II.B.1.4 for a detailed discussion of the needs assessment methodology.) The four health districts and their counties referred to in this section are:

1. District I – eight counties of the central and northwest regions: Bernalillo, Cibola, Los Alamos, McKinley, Sandoval, San Juan, Torrance, and Valencia.

2. District II - eight counties of the northeast region: Colfax, Harding, Mora, Rio Arriba, San Miguel, Santa Fe, and Union.
3. District III - eight counties of the southwest region: Catron, Dona Ana, Grant, Hidalgo, Luna, Otero, and Socorro.
4. District IV – nine counties of the southeast region: Chaves, Curry, De Baca, Eddy, Guadalupe, Lea, Lincoln, Quay, and Roosevelt.

Each of the four district workshops included breakout sessions on 10 priority topics that had been identified for the MCH Needs Assessment.

Topic No.	Priority Topic for MCH Needs Assessment, 2005
1	Immigrants and Maternal Child Health (MCH)
2	Access to and Use of Health care, Health Insurance and Coverage
3	Transition for Youth with Special Health Care Needs
4	Preconception and Prenatal
5	Male Involvement and Fatherhood
6	Obesity
7	Teen Births (ages 15-17) and Chlamydia
8	Violence
9	Injury Prevention
10	Positive Youth Development

The Needs Assessment report has 10 sections (II.B.4.1 to II.B.4.10) that present for each priority topic the following:

- *Synthesis of MCH program capacity* by pyramid level, NM health district, and population group
- *Synthesis of recommendations on needed policies, programs and services* by pyramid level, health district, and population group
- *Constraints and barriers*
- *Community Strengths and Resources*

The numbering for the subsections (a-d) indicates that all pyramid levels of service are presented together on each priority topic.

Seven categories of population groups are used in the Needs Assessment and include the standard three of MCH programs. The additional categories were defined by DOH/FHB staff given the broad reach of many health services. The

categories are: 1) pregnant women and mothers, 2) infants, 3) children, 4) CYSHCN, 4) teens (including female and male teens), and 6) males. The seventh category, “all”, includes all six population groups.

Time constraints during the breakout sessions on the 10 priority topics (five topics were considered simultaneously) prevented consideration of *community strengths and resources* for all topics during the district workshops. A heading and discussion of community strengths and resources is included in the Needs Assessment report only if there were citations.

The discussion of *program capacity* and *recommendations* for each priority topic is followed directly by Excel tables A, B, C, and D.

- Table A displays *program capacity* as identified at the districts’ Needs Assessment workshops.
- Table B uses a different pattern for each population group; it also gives a count of citations for *program capacity* for each priority topic by population group, pyramid level, and health district.
- Table C (the same approach as Table A) displays *recommendations* for each priority topic that were cited at the four district workshops.
- Table D (the same approach as Table C) uses a different pattern for each population group; it also gives a count of citations for *recommendations* for each priority topic by population group, pyramid level, and health district.

At the Needs Assessment workshops, staff from each district cited its “most important” recommendations and other recommendations, some of which were described as “no cost/low cost.” Tables B and D include asterisks for each “most important” recommendation and parenthetical notes for each “no cost/low cost” recommendation.

Services and recommendations for children and youth with special health care needs are only identified when they pertain specifically to that population. Otherwise, this population group is encompassed in services and recommendations for infants, children and teens.

Section 11.B.4.11 presents other issues by health district that identified by participants in the four Needs Assessment workshops.

Section 11.B.4.12 presents the strengths and weaknesses of needs assessment methods and procedures.

II.B.4.1a-d Immigrants and Maternal Child Health (MCH)

MCH Program Capacity and Related Recommendations

During the Needs Assessment workshops, 47 services were cited that provide a snapshot of MCH program capacity for immigrants in New Mexico. About half (24 citations) of these are for enabling services, another 15 are infrastructure building services, eight are direct services, and only one is a population based service. Most services cited benefit not only the MCH population but also other groups. Services for pregnant women and mothers were cited eight times, those for children and teens were cited five times each, those for infants were cited 4 times, only one service was given for CYSHCN, and none was given for males. (See Table A, Sheet C1 for a detailed description of program capacity; Table B, Sheet CC1 for a count of program capacity citations; Table C, Sheet R1 for a detailed description of recommendations; and Table D, Sheet RC1 for a count of recommendations.)

Direct Health Care Services

Program capacity was cited in Districts II and IV including family reliance on county indigent funds, dental and vision services (for children) and primary care, prenatal care, and medications at low-cost for all population groups. Service providers cited at the workshops include local health offices, school-based health centers, non-profit groups, and federally-qualified health centers. Some county indigent funds support preventive services, such as health education.

Recommendations were cited in all four districts. The seven recommendations impact all population groups and concern funding for immigrants' health care. Two recommendations are: assure that county MCH grants include funding for direct services, and provide high-risk care for undocumented individuals. The others are about county indigent funds (CIF):

- Redesign CIF to be prevention oriented
- Prioritize needs for CIF and use them effectively
- Work to increase consistency in CIF policies and procedures across counties (e.g. some cover immigrant health care costs; some do not)

Enabling Services

Program capacity was cited in all four districts. Across all districts, the Healthier Kids Fund (statewide program) provides coverage for primary care for children who have no other source of payment. Public health staff and County MCH Councils' staff (now part of the larger County Health Coalitions) cited many forms of advocacy, assistance with eligibility,

and transportation that also benefit all population groups. District I cited hiring bilingual staff (both English/Spanish and English/Vietnamese) and has Spanish material on access to services. District IV County MCH specifically cited Medicaid Category 85, emergency medical care for aliens, which benefits all population groups.

Recommendations were cited in all four districts. The 11 recommendations, most of which would benefit all population groups, cover funding needs for care coordination and transportation; greater attention to cultural competency and sensitivity, e.g. ensuring adequate language skills and translation; and more flexibility of services, e.g. accepting walk-in clients, and evening clinic hours. One recommendation to conduct more group education clinics would impact specific population groups, e.g., prenatal clinics (pregnant women and teens); well-child clinics (children), and chronic disease clinics (women, CYSHCN, and men).

Population Based Services

Program capacity was cited only by District IV staff. Mammograms are available, regardless of citizenship status, through the Breast and Cervical Cancer Grant.

Recommendations were cited in Districts II and IV. Four of the five recommendations would impact all population groups; these concern various media strategies (such as a public health TV show like ER and Public Services announcements in English and Spanish) to increase public awareness of the health needs of immigrants in New Mexico and to increase immigrants' awareness of health care services. A recommendation to get local celebrities to speak on radio shows to promote such healthy behavior and practices as taking folic acid and breastfeeding would benefit pregnant women and teens, and infants.

Infrastructure Building Services

Program capacity was cited in all four districts. Many of these services benefit all population groups, e.g., community groups in all districts are working to improve immigrants' access to services. In addition, the City of Santa Fe in District II has established an Immigrant Task Force. In Chaves County, several health partners (local physicians, the County MCH Council, local public health offices, and University of New Mexico's Family Practice Residency Center) have a coordinated policy to assure that all pregnant women and teens can obtain prenatal care.

Recommendations were made in all four districts. Eighteen recommendations cover a wide range of issues such as government policies (federal and state) on immigrant access to health care, more funding for community health workers,

greater coordination of agencies providing health care services to immigrants, and incentives for health care staff providing services. Most of these impact all population groups; several others impact specific groups such as children, teens, and CYSHCN.

Constraints/Barriers related to immigrants and MCH were cited in all four districts. While they covered all levels of the health care pyramid, most constraints and barriers were concerned with enabling and infrastructure building issues. For example, District I staff cited that lack of coordination among different parts of the health system and that immigrants are often seen in multiple locations by several providers who do not have the complete histories or established relationships with their immigrant clients due to various factors such as recent migration (moving within the state or moving into the state from elsewhere), fear, and convenience of services (i.e. access issues such as location, service delivery hours, etc.). Importantly, District II staff cited the fact that the Federally-Qualified Health Centers were not filling the gap in service delivery for immigrants. District III staff cited the competing demand for health dollars between primary health care (i.e. prevention education and services) and treatment, especially tertiary care (i.e. hospitals). District IV staff cited problems with staff turnover, especially of those serving the immigrant population, and also the problem of co-pays and cost of medication. Further, some providers whose financial policy requires making a profit are out-of-the-reach for many poor immigrants.

Community Strengths and Resources, cited only in District II, are that New Mexico has a multi-cultural heritage, immigrants contribute to the economy, and the public health is based on social justice and a broad population-based view of health needs.

Table A. Program Capacity for Immigrants and MCH

Pyramid Level	District	Current Capacity by Activities Identified	MCH Population Group
Direct	II	Villa Therese Catholic Clinic and La Familia serve immigrants. An estimated 80% of the La Familia clients are undocumented immigrants.	All
Direct	II	Ayundando Nuestros Ninos (ANN) Project provides dental and eye services in Santa Fe.	Child
Direct	IV	County MCH provides prenatal care, high-risk prenatal care, CMS, and so forth as funded by Title V MCH.	All
Direct	IV	Chaves County has a community pharmacy where medications are available at cost plus \$4.	All
Direct	IV	Dental clinic provides services at schools.	Child & Teen
Enabling Services	I	Public Health office services do not ascertain immigration status to remove such concern at time of registration for services (CMS, immunization, WIC, family planning).	All
Enabling Services	I	Sandoval County Indigent funds are being used in a different way to improve access to University Hospital. The county uses indigent funds partly for preventive services like health education rather than spending it all on crisis management.	All
Enabling Services	I	First Choice serves as an advocate and does outreach focus groups in Spanish based on community requests.	Maternal Infant
Enabling Services	I	District I PHD has Spanish medical terminology classes, interpreter's class, and is hiring bilingual employees (English/Spanish and English/Vietnamese).	All
Enabling Services	I	Spanish booklet "Where can immigrants go to get services."	All
Enabling Services	I	Catholic Charities has short-term case management program.	All
Enabling Services	I	Block leaders' project of St. Joseph's Foundation does outreach with lay people.	All
Enabling Services	I	Vietnamese duola program.	Maternal & Infant
Enabling Services	II	Healthier Kids Fund serves immigrant children in need.	CYSHCN
Enabling Services	II	Clinicians and public health staff are client advocates and in some cases provide case management.	All

Table A. Program Capacity for Immigrants and MCH

Pyramid Level	District	Current Capacity by Activities Identified	MCH Population Group
Enabling Services	II	Santa Fe has adopted a Living Wage with a minimum of \$8.50 per hour compared to \$5.15 for federal/state minimum hourly wage. To qualify for the Santa Fe Living Wage, one must have a social security number.	Maternal & Teen
Enabling Services	III	Dofia Ana County has a good outreach model to get people to services using promotoras.	All
Enabling Services	III	Dofia Ana County is the only county that allows indigent care funds to be paid for immigrants' health care.	All
Enabling Services	IV	County MCH provides coordination of services to assure immigrants get the best possible care and is the biggest supporter of services to immigrants.	All
Enabling Services	IV	Women Infants and Children (WIC) Program	Maternal, Infant, Child & Teen
Enabling Services	IV	Presumptive Eligibility - Medicaid On-Site Application Assistance (PE-MOSAA) is offered in local health offices.	All
Enabling Services	IV	County MCH tries to assure that people use emergency medicine option, i.e. Medicaid Category 85, Emergency Medical Care for Aliens.	All
Enabling Services	IV	In Lincoln County, County MCH is using indigent funds to support services for immigrants.	All
Enabling Services	IV	County MCH provides transportation to essential services for those who do not have reliable transportation in these largely rural counties.	All
Enabling Services	IV	Curry County van	All
Enabling Services	IV	Immigrants often rely on extended family for childcare, a model non-immigrants might learn from.	Infant & Child
Population Based Services	IV	Mammograms are available, regardless of citizenship status, through the Breast and Cervical Cancer Grant.	Maternal
Infrastructure Building Services	I	Community Coalition for Healthcare Access will be negotiating UNM to reduce their financial requirement of ½ down payment prior to receiving services so that the undocumented can access care.	All

Table A. Program Capacity for Immigrants and MCH

Pyramid Level	District	Current Capacity by Activities Identified	MCH Population Group
Infrastructure Building Services	I	Grassroots organizations (community health partnerships, school parent groups, Mexican consulate)	All
Infrastructure Building Services	II	Dream Act enables immigrants to apply for citizenship after 2 years of college.	Maternal & Teen
Infrastructure Building Services	II	City of Santa Fe has established an Immigrant Task Force.	All
Infrastructure Building Services	III	The Emergency Medical Treatment and Active Labor Act (EMTALA) requires any hospital, which accepts federal funds to provide emergency treatment regardless of the patient's ability to pay. When the uninsured seek urgent care at a local hospital they may be covered under EMTALA.	All
Infrastructure Building Services	IV	In Chaves County, there is an organized & coordinated policy to assure that any woman can obtain prenatal care. This policy is carried out by such partners as local physicians, County MCH, local health offices, and the UNM's Family Practice Residency Center.	Maternal & Teen
Infrastructure Building Services	IV	Chaves County transportation focuses on mothers and children and what benefits the family.	Maternal, Infant, Child & Teen
Infrastructure Building Services	IV	In Lincoln County, the Community Action Committee addresses alcohol, substance abuse, and teen pregnancy all together. Partners are the MCH Coordinator, superintendent of schools, school nurses, school based health centers, hospital, and parenting programs.	All
Infrastructure Building Services	IV	In Lincoln County, the Community Action Committee addresses alcohol, substance abuse, and teen pregnancy all together. Partners are the MCH Coordinator, superintendent of schools, school nurses, school based health centers, hospital, and parenting programs.	All

Table B. Number of Program Capacity Citations for Immigrants and MCH*

Population Group	Direct				Enabling				Population				Infrastructure			
	District I	District II	District III	District IV	District I	District II	District III	District IV	District I	District II	District III	District IV	District I	District II	District III	District IV
Pregnant Women & Mothers					2*	1		1				1		1		2
Infants					1			2								1
Children		1		1				2								1
CYSHCN						1										
Teens				1		1		1						1		2
Males																
All		1		2	6	1	2	6					2	1	1	2

Table C. Recommendations on Immigrants and MCH

Pyramid Level	District	Recommendations Cited at MCH Needs Assessment Workshops	MCH Population Group
Direct	I	Redesign county indigent funds to be prevention oriented. *	All
Direct	II	Use Category 87 – indigent fund.	All
Direct	III	Prioritize needs for county indigent funds and use them effectively	All
Direct	III	Make requirements for indigent funds consistent across counties.	All
Direct	III	Provide high-risk care for undocumented individuals. *	All
Direct	IV	Work to assure that county MCH grants include funding for direct services. *	All
Direct	IV	Work to increase consistency in indigent funding from county to county since policies governing county indigent funds vary; some cover immigrant health care costs; some do not. *	All
Enabling Services	I	Support cultural competency, and set up “language line” (a phone-up translation service).	All
Enabling Services	II	Think of transportation as relevant to services. (no cost/low cost)	All
Enabling Services	II	Support more attention to cultural sensitivity. (no cost/low cost)	All
Enabling Services	II	Ensure flexibility of services, e.g., accept walk-ins; hold evening clinic hours; conduct group prenatal, well-child, and chronic disease clinics. *	All
Enabling Services	II	Use word of mouth for spreading word about our services; assure safety. (no cost/low cost)	All
Enabling Services	II	Empower front line staff. (no cost/low cost)	All
Enabling Services	II	Have a heart for clients. (no cost/low cost)	All
Enabling Services	III	Provide funds for travel to health care & related health care services for undocumented individuals. *	All
Enabling Services	III	Continue county MCH funding for care coordination, and transportation *	All
Enabling Services	IV	Increase children’s access to dental care by having volunteers bring dental van to school.	Child
Enabling Services	IV	Address transportation needs (Lincoln County) and the need for prenatal vitamins or starter kits (through TARGET and Wal-Mart).	Maternal & Teen

Table C. Recommendations on Immigrants and MCH

Pyramid Level	District	Recommendations Cited at MCH Needs Assessment Workshops	MCH Population Group
Population Based Services	II	Conduct public relations promoting public health needs of immigrants, e.g., look at relationship between immigrants and those they work for/serve and show to emphasize their value.*	All
Population Based Services	II	Create a public health TV show, like ER. (no cost/low cost)	All
Population Based Services	II	Use PSAs on radio in English and Spanish. (no cost/low cost)	All
Population Based Services	IV	Raise awareness of MCH successes and needs by getting public health-human interest articles in local or statewide newspapers.	All
Population Based Services	IV	Get local celebrities to speak on radio shows about topics such as folic acid and breastfeeding.	Maternal & Teen
Infrastructure Building Services	I	Formulate governmental and humanitarian policies to support immigrant access to healthcare. *	All
Infrastructure Building Services	I	Fund community health workers; support advocates and leaders in immigrant community; and promote pro-active partnering with agencies and larger programs to address immigration issues. *	All
Infrastructure Building Services	I	Support infrastructure (existing projects, staff).	All
Infrastructure Building Services	I	Get agencies to talk to each other.	All
Infrastructure Building Services	I	Support cultural competency, and set up "language line" (a phone-up translation service).	All

Table C. Recommendations on Immigrants and MCH

Pyramid Level	District	Recommendations Cited at MCH Needs Assessment Workshops	MCH Population Group
Infrastructure Building Services	II	Use School Based Health Centers/Schools Nurses to bridge the gap (bilingual). *	Teen
Infrastructure Building Services	II	Increase teambuilding with provider community; work on relationships. *	All
Infrastructure Building Services	II	Expand statewide Healthy Kids Fund to provide services to more people. *	CYSHCN
Infrastructure Building Services	II	Conduct public relations/advocacy with the NM legislature on the importance of prevention. (no cost/low cost)	All
Infrastructure Building Services	II	Educate health supervisors and legislators. (no cost/low cost)	All
Infrastructure Building Services	II	Increase inclusivity of the Children's Cabinet. (no cost/low cost)	Infant, Child & Teen
Infrastructure Building Services	II	Focus on no cost/low cost perks for staff morale. (no cost/low cost)	All
Infrastructure Building Services	II	Pay extra for translation. (no cost/low cost)	Maternal, Male, Child & Teen
Infrastructure Building Services	III	Include specialists in Federally-Qualified Health Centers. *	All
Infrastructure Building Services	IV	Use Congressional resources more. Try to get U.S. lawmakers to recognize the problem and make policies that are positive for immigrant health and health care access. *	All

Table C. Recommendations on Immigrants and MCH

Pyramid Level	District	Recommendations Cited at MCH Needs Assessment Workshops	MCH Population Group
Infrastructure Building Services	IV	Increase partnerships with county commissioners and get them to recognize the problem and make policies that are positive for immigrant health and health care access.	All
Infrastructure Building Services	IV	Use different terminology for “immigrants,” e.g., “non-Medicaid eligible,” “medically indigent” given that public funding of health care costs for undocumented immigrants is politically sensitive.	All
Infrastructure Building Services	IV	Expand model of organizations such as Altrusa that “adopts” partners who volunteer (nurse practitioners, physicians, etc.) services.	All

Table D. Number of Recommendations on Immigrants and MCH*

Population Group	Direct				Enabling				Population				Infrastructure			
	District I	District II	District III	District IV	District I	District II	District III	District IV	District I	District II	District III	District IV	District I	District II	District III	District IV
Pregnant Women & Mothers								1				1		1		
Infants														1		
Children								1						2		
CYSHCN														1		
Teens								1				1		3		
Males														1		
All	1	1	3	2	1	6	2			3		1	5	4	1	4

II.B.4.2 a-d Access to and Use of Health Care, Health Insurance and Coverage

MCH Program Capacity and Related Recommendations

During the Needs Assessment workshops, 52 services were cited that provide a snapshot of MCH program capacity in terms of access to and use of health care services, health insurance and coverage in New Mexico. Seventeen citations each were direct and infrastructure building services, 16 were enabling, and only three were population based services. Most services across all pyramid levels (31 citations) benefit all population groups. Services for children, CYSHCN, and teens were cited six times each; those for infants were cited three times; only one service was given for pregnant women and mothers; and none was given for males. Many of the citations on this priority topic involve access to services by immigrants and undocumented people reinforcing the high priority given to this population group by both public and private health care providers. (See Table A, Sheet C2 for a detailed description of program capacity; Table B, Sheet CC2 for a count of program capacity citations; Table C, Sheet R2 for a detailed description of recommendations; and Table D, Sheet RC2 for a count of recommendations.)

Direct Health Care Services

Program Capacity was cited in the four districts. Health centers and/or hospitals in Columbus, Deming, and Socorro (District III and IV) were cited as providing health services to all population groups. Districts I, II, and IV also cited using county indigent funds to benefit all population groups. While existing in many counties in the state, school-based health centers (cited only in District IV) serve teens. Dental clinics (District II) serve pregnant women, mothers, children and teens. While existing in all districts, DOH health offices (cited only in District I) provide immunizations for infants and children. Specialty clinics for cleft palate (District I) and nephrology (District II) serve CYSHCN.

Recommendations (only one was cited and only in District II) and it calls for ensuring that county indigent funds can be used to cover immigrant health care needs.

Enabling Services

Program Capacity was cited in all districts, although most were in Districts I and II (14 of 15 citations). The enabling services cited that benefit all population groups concern various means of funding health care. Public health staff in District I reported that 75 percent of health care in New Mexico is publicly funded. Sources of funding cited include: Medicare Section 10.1 providing support to hospitals to serve undocumented people (Districts I and II) including those apprehended

at border check points (District III). District I staff stated that presumptive eligibility for Medicaid can still be done every 6 months.

District II health staff cited school-based health centers that serve immigrants and their children and also that Federally-Qualified Health Centers use sliding scale fees. District II cited that most children are covered by Medicaid and that Arroyo Chamiso Pediatric Center (affiliated with St. Vincent's Regional Medical Center), which serves infants, children, and teens, offers payment plan options in addition to accepting Medicaid. District II reported that CMS funds for CYSHCN services include documented children and youth and that the NM Medical Insurance Pool is available for those children and youth with chronic conditions. CMS staff also works with youth who have high-cost chronic conditions, whether in rural or urban community health centers, to provide health care.

District I cited several models to improve access to and use of health care to all population groups including immigrants and undocumented people. These include:

- ***Patient advocate model*** at Rehoboth McKinley Hospital in Gallup that coordinates and assists those without financial resources (including immigrants and undocumented people) with finding service payment sources.
- ***Family empowerment models*** include Family Support New Mexico and Family Leadership for Education, Culture, and Health Access (FLECHA), in 6 communities including Albuquerque and Laguna, which are funded by grants from the NM Community Foundation and a Robert Wood Johnson Fellowship.
- ***Advocacy model***, Community Coalition for Health Care Access that is working to improve access to care (including language interpretation services) for immigrants and undocumented people at UNM Hospital in Albuquerque.

Recommendations were cited in two districts: to provide incentives to get people to attend family empowerment groups and to find private funds to support this, empower family to speak out about their health care needs and issues (District I) and to solicit client feedback on services (District II),

Population Based Services

Program Capacity was cited in District II where staff noted that immunizations rates are increasing for infant, children, and teens.

Recommendations were cited in Districts I and IV. These are to:

- In District I, determine ways to make prevention real to people who tend to only use health care when sick – tell real stories about real people and demonstrate why prevention is important.
- In District IV, conduct a media blitz (with positive messages) to raise awareness of the importance of preventive care and existing services. Such an information, education, communication strategy should use multiple channels for communication such as, regional/state/local collaboratives, county/city government, business roundtables, media (radio, TV, print, and Internet) health fairs, various health councils (e.g. MCH Councils, TUPAC).

Infrastructure Building Services

Program Capacity was cited in all districts although over 80 percent (14 of 17 citations) were in Districts II and III. Seventy percent (12 citations) were for services that benefit all population groups. There were two citations each for CYSHCN and youth, and there was one for children.

In District I, a **comprehensive service model** that benefits all population groups is the Sandoval County Commons; it provides services in one location using a community-health worker model encompassing public health, primary care, behavioral health, and domestic abuse.

Several community-based groups focus on access to health care for all population groups. These include McKinley County Health Care Access Coalition (District I); county health councils (cited in District IV but that exist in most counties); Health Centers of Northern New Mexico (District II), which is trying to expand clinic access to small mountain communities; Community Action Team in Deming, Luna County; and Access to Care Committee in Doña Ana County (both in District III). The Doña Ana group is sponsored by the County Health and Human Services Department and involves all providers to improve referrals and to keep people from falling through the cracks.

District II gave examples of mobile services that increase access to primary health and dental care (Taos and Espanola) for all population groups. The Healthy Tomorrows Van (Santa Fe) a school-based primary care van, administered by Presbyterian Medical Services, that is stationed at different elementary schools each week. WIC has several mobile units that serve 600 clients per month in small communities and colonias.

Other examples of capacity to improve access for all population groups are: Union County hospital that established a primary care center (District II) with services funded by Medicaid because private doctors were not accepting Medicaid patients; Catron County's public health office that recently opened after a nine-year hiatus (District III); and five counties (Catron, Doña Ana, Grant, Hidalgo, and Luna) in District III that use management information systems to connect providers.

School-based health centers help to improve access for children and teens (cited in District II but many districts have such centers). The Healthy Start Adolescent Family Life Program in Las Cruces (District III) serves a large teen population. District II cited services for CYSHCN that include community-based multidisciplinary pediatric specialty clinics (e.g. asthma clinics) and efforts by physicians in Santa Fe to keep nephrology clinics as well as nutrition and screening services.

Recommendations were cited in all four districts. Of the 33 recommendations on the priority topic of access to and use of health care, 27 were infrastructure building services (IBS).

District I's most important IBS recommendations are:

- Replicate the patient advocacy model of Rehoboth McKinley Hospital.
- Expand Medicaid to include undocumented individuals; this would require advocacy at the national level to change Federal legislation.

District II's most important IBS recommendations are:

- Create a state health insurance program.
- Adopt a standardized sliding-fee scale for Federally-Qualified Health Centers.
- Meet with contractors of Managed Care Organizations to increase coverage.

District III's most important IBS recommendations (similar to those cited in district I and II) are:

- Provide universal health care coverage.
- Ensure more consistent regulation and enforcement of state regulations on different types of state-funded services and programs (including county indigent funds, which are a direct service).
- Increase personal empowerment and responsibility among public health staff to address access barriers (attitudes of staffs of Income Support Division of NM Department of Human Services, Federally-Qualified Health Centers, etc.).

District IV's most important IBS recommendations are:

- Recognize the rural ness of the district and its special impact on access to services.
- Bring partners together to address health care needs and delivery of services; partners include parents, students, schools, teachers, faith communities, and business.
- Seek funding from foundations and other groups, e.g., Annie E. Casey Foundation (based in Baltimore, MD), Con Alma Foundation, and other funding sources such as Dairy Farmers/Dairy Council.

Constraints/Barriers related to access to and use of health care, health insurance and other coverage were cited in all four districts.

District I's cited 20 issues that concern different levels of services. For direct services, county indigent funds have varying regulations for eligibility causing confusion among clients; e.g., Bernalillo County indigent funds allow services for the undocumented, but UNM hospital does not serve them. There is inadequate access to services for immigrants including undocumented persons to particular types of services (cited were prenatal and CYSHCN). The statewide Healthier Kids Fund is not able to cover the health care needs among CYSHCN and undocumented children and youth because funding has been frozen at 1999 levels. Access is very limited for young males ages 20-30.

In terms of enabling services, several were cited: limited transportation, long waiting times at clinics and Medicaid re-certification every six months are access barriers; there are fewer Angel Flights since September 11, 2001. For infrastructure building services, constraints cited by District I are many and mostly about funding. Those related to Medicaid and/or SCHIP are: that immigrants and undocumented persons are not covered; well-child services have been cut by DOH public health offices (was a source of immigrant health care); and Native Americans are told to use the Indian Health Service, but its services are not sufficient due to federal government cuts in funding. Access to well-child services provided by Managed Care Organizations (MCOs) under Medicaid Salud contracts is not adequate and may be due to the tension between providing health services to needy children and MCOs financial structure.

Rural and urban community health centers have insufficient funds given the demand for services; there are access barriers and also administrative inefficiencies due to variations among health centers in the level or percent of co-pays, sliding-scale fees, and the cost of medication (still to high for many clients);

Two other infrastructure building issues were cited: NM state police stop undocumented immigrants at checkpoints and effectively block their access to health care. Public health staff and partners are concerned about discriminatory laws

passed recently (Arizona) or currently being considered (Colorado) that cut or limit health services for immigrants and the undocumented.

District II cited 10 issues considered constraints or barriers to accessing health services. In terms of direct services, many clinics do not accept indigent funds. Dental services are both fragmented (in terms of overall health care) and inadequate in rural clinics and even in school-based health centers. Those needing health and dental care often travel to Texas or Mexico. The rural character of some counties is a barrier to care even if resources (especially human resources) were sufficient. In rural counties, hospitals risk closing if the ratio is too high of births funded by Medicaid to those paid by health maintenance organizations.

Infrastructure issues are similar to some cited above for District I. Some services are not covered by Medicaid such screening and nutrition (for well children). Some private providers do not accept Medicaid. Some clinics do not have sliding fee scales. In general, there is competition for services and limited resources.

District III cited 21 barriers and constraints. Many of these result from the rural nature and a low population density of the district's counties (e.g. Catron county) making service delivery difficult and expensive. The many barriers that were cited include:

- Some counties in the district are fighting to maintain services and funding, and other counties do not even have services.
- Geographic problem-solving is not always an appropriate approach; it depends on the issue.
- Due to the restricting process, Catron County is being pulled out of its regional relationship with Grant, Hidalgo and Luna counties that has taken years to develop.
- There are inconsistent regulations for eligibility for various health and human needs resources across counties and state programs.
- Presumptive eligibility for Medicaid is determined at the clinic in Catron County; many people have to go to the city of Socorro in another county to apply.
- Many people potentially eligible for Medicaid are not enrolled due to various obstacles.
 - Six-month recertification requirement is a barrier.
 - In Luna County, Income Support Division staff picks and chooses who is eligible based to some extent on biased and discriminatory attitudes.

- In Catron County, there is no radio station, and it is hard to get information into communities about Medicaid and other services.
- In Socorro County and most other ISD offices, there are various deterrents such as guards, metal detectors, barred windows, etc.
- Co-pays for programs such as First Step at Memorial Medical Center (for high-risk clients) and Rural Primary Health Care-funded clinic services in Catron county (many clients feel these services should be free).
- In Luna County, Deming Hospital's administration wants more paying patients using emergency room and urgent care services to offset the number of non-paying clients. Can indigent funds be used for non-paying clients? The hospital gets indigent funds at this point.
- The cost of programs and services in Catron County is high because of the small population and small number of births.
- There is no pharmacy in Catron County, and insurance does not cover medications dispense from the clinic.
- Socorro County is seeking funding and help for case management services.
- Luna County's perinatal program for undocumented persons is not well recognized.

Additional constraints were cited:

- Lack of programs and services in very small frontier counties (e.g. Hidalgo and Luna).
- Lack of state oversight and consistency across counties in terms of RPHC and ISD (use of indigent funds, level of co-pays, etc.).
- Political and other repercussions for "whistle blowers" and those for whom they advocate.
- Hospitals do not know how to bill for Medicare Section 10.11 funds.
- After June 2005, there will be no funding for some of the MCH program in Socorro that serves non-Medicaid eligible, Spanish-speaking pregnant women and families.

District IV workshop participants cited 10 issues, some of which are similar to other districts' issues such as access barriers in rural counties. Also, the demand for prenatal indigent care exceeds providers' resources, partly because clients come into Lincoln County from Otero County, which lacks prenatal services. Adults, ages 21 to 65, lack access to services for various reasons: transportation, limited education (resulting in low priority given to good health behavior and prevention of illness and accidents), doctors not being paid by insurance, etc.

The health care system in District IV faces growing demands and inadequate resources due to increasing health care needs of the U.S. military personnel who are based in the district and also the needs of undocumented persons. This demand makes access to health services more difficult for county residents. Another strain on the system is that the safety net of UNM is dwindling.

There are financial issues as well such as the inability of the working poor and underinsured to afford co-pays, and there is no money to support or subsidize sliding-scale fees. There are a number of concerns about the legislated expansion of school-based health centers: public health staff has not been included in the dialogue on: a) planning the locations of the new centers, b) the most effective and efficient use of funds including how the funds will expended; c) hiring and salaries of the new providers needed to staff new centers, and d) difficult issues about the approach to the health education of youth (ranging from abstinence-only to more comprehensive sexuality education as well as access to condoms and other contraceptive methods for STD and pregnancy prevention).

Table A. Program Capacity for Access to and Use of Health Care, Health Insurance & Coverage

Pyramid Level	District	Current Capacity by Activities Identified	MCH Population Group
Direct Services	I	DOH health offices provide immunization services.	Infant & Child
Direct Services	I	Cleft palate clinics in Gallup are working with HIS.	CYSHCN
Direct Services	II	Santa Fe, Penasco, Embudo have dental clinics.	Maternal, Child & Teen
Direct Services	II	UNM has nephrology clinics in Santa Fe.	CYSHCN
Direct Services	III	Socorro MCH Program serves 25 families and pregnant women who are Spanish speaking and not Medicaid-eligible. The County has helped with some funding.	All
Direct Services	III	Ben Archer Clinic and Deming Health Center provide services in Luna County	All
Direct Services		School-based health centers	Teen
Direct Services	IV	Re-opened Nor-Lea Hospital District	All
Enabling Services	I	Patient advocate model working at Rehoboth McKinley Hospital in Gallup provides coordination, assistance with finding service payment sources, etc. for immigrant/undocumented people and others without resources. Hospital itself funds this position. This is a model for advocacy. San Juan Medical Center, Farmington, is being given information about this model.	All
Enabling Services	I	NM Medical Insurance Pool is available for people with chronic conditions. CMS works with youth with high cost chronic conditions to Rural and urban community health centers provide services.	CYSHCN
Enabling Services	I	Community Coalition for Health Care Access is working to improve access to care for immigrants/undocumented at UNM Hospital, Albuquerque. The coalition has sued UNM Hospital around data issues and provision of interpretation services. This is a model for advocacy.	All
Enabling Services	I	Family empowerment models such as Family Support New Mexico and Family Leadership for Education, Culture, and Health Access (FLECHA) is funded in 6 communities (including Albuquerque and Laguna in District 1) through the NM Community Foundation and a Robert Wood Johnson Fellowship for Louise Kahn. This is an 8 hour course through existing groups such as early child care and Head Start.	All
Enabling Services	I	CMS can serve undocumented children and youth.	CYSHCN

Table A. Program Capacity for Access to and Use of Health Care, Health Insurance & Coverage

Pyramid Level	District	Current Capacity by Activities Identified	MCH Population Group
Enabling Services	I	75% of health care in New Mexico provided through public dollars.	All
Enabling Services	I	Presumptive Eligibility for Medicaid can still be done every 6 months.	All
Enabling Services	I	Federal dollars are available to hospitals to serve undocumented people.	All
Enabling Services	I	County Indigent funds exist.	All
Enabling Services	II	Most children are covered by Medicaid.	Child & Teen
Enabling Services	II	Federally-funded health centers use sliding scale fees.	All
Enabling Services	II	Hospital-based primary care physicians can access indigent and Medicaid funds.	All
Enabling Services	II	School-based Health Centers are helping immigrants and their children.	All
Enabling Services	II	People can apply for county indigent funds for emergency situations.	All
Enabling Services	II	In Santa Fe, the Arroyo Chamiso Pediatric Center accepts Medicaid and also gives people a payment plan option.	Infant, Child & Teen
Enabling Services	III	Medicare Section 10.11 has dollars for hospitals based on numbers of undocumented persons and numbers of apprehensions at border check points.	All
Enabling Services	IV	County indigent funds	All
Population Based Services	II	Immunization rates are increasing.	Infant, Child & Teen
Infrastructure Building Services	I	Sandoval County Commons is providing comprehensive services in the same location using a community health worker model encompassing public health, behavioral health, domestic abuse, primary care.	All

Table A. Program Capacity for Access to and Use of Health Care, Health Insurance & Coverage

Pyramid Level	District	Current Capacity by Activities Identified	MCH Population Group
Infrastructure Building Services	I	McKinley County Health Care Access Coalition.	All
Infrastructure Building Services	II	Mobile dental services are being created: Community Dental Service brought mobile dental care to Taos; a CDC grant will fund mobile services to Espanola; Santa Fe will have mobile services this summer.	All
Infrastructure Building Services	II	In Santa Fe County, Presbyterian Medical Services van (with an AAP grant) goes to elementary schools and provides primary and dental care.	All
Infrastructure Building Services	II	Health Centers of Northern New Mexico is trying to expand clinic access to small mountain communities.	All
Infrastructure Building Services	II	Funding for new School-based Health Centers is available.	Child & Teen
Infrastructure Building Services	II	Physicians in Santa Fe are fighting to keep nephrology clinics and services, nutrition and screening services.	CYSHCN
Infrastructure Building Services	II	There are some volunteer-based clinics in state.	All
Infrastructure Building Services	II	In Union County, the hospital established a primary care center; services funded by Medicaid are provided because private doctors were not accepting Medicaid patients.	All
Infrastructure Building Services	III	Dona Ana County has an Access to Care Committee sponsored by the County Health and Human Services Department involving all providers to improve referrals and keep people from falling through the cracks.	All
Infrastructure Building Services	III	Dona Ana County has an MIS (Management Information System) to connect providers.	All

Table A. Program Capacity for Access to and Use of Health Care, Health Insurance & Coverage

Pyramid Level	District	Current Capacity by Activities Identified	MCH Population Group
Infrastructure Building Services	III	Grant, Catron, Hidalgo and Luna Counties have a regional MIS.	All
Infrastructure Building Services	III	Healthy Start Adolescent Family Life Program in Las Cruces serves a high teen population	Teen
Infrastructure Building Services	III	Catron County now has a public health office after nine years without one.	All
Infrastructure Building Services	III	Luna County (Deming) has a Community Action Team that works on access issues.	All
Infrastructure Building Services	IV	County health councils are top partners, each working on 2 priorities (access to care, teen pregnancy, etc.).	All

Table B. Number of Program Capacity Citations for Access to and Use of Health Care, Health Insurance and Coverage*

Population Group	Direct				Enabling				Population				Infrastructure			
	District I	District II	District III	District IV	District I	District II	District III	District IV	District I	District II	District III	District IV	District I	District II	District III	District IV
Pregnant Women & Mothers		1														
Infants	1					1				1						
Children	1	1				2				1				1		
CYSHCN	1	1			2									2		
Teens				1		2				1				1	1	
Males																
All			2	4	7	4	1	1					2	5	4	1

Table C. Recommendations on Access to and Use of Health Care, Health Insurance & Coverage

Pyramid Level	District	Current Capacity Activities Identified	MCH Population Group
Direct Services	I	Increase access to emergency contraception. *	Male & Teen
Enabling Services	I	Make public health offices more “male-friendly.” *	Male & Teen
Enabling Services	I	Hold a conference for young men to provide training, education, and support.	Male & Teen
Enabling Services	I	Help small business to develop business plans to reach out to employable males.	Male & Teen
Enabling Services	I	Take information and education to where men are (e.g., barbershops, bars)	Male
Enabling Services	I	Overcome barriers to using male language.	Male & Teen
Enabling Services	II	Make public health offices/clinics more “male-friendly” (e.g., add posters with men, magazines for men). *	Male & Teen
Enabling Services	II	Get St. Vincent’s Hospital, Santa Fe to reach out more to males (e.g., prostate screening program, sessions on alcohol abuse prevention).	Male & Teen
Population Based Services	IV	Create greater awareness of the need for programs that focus on males and publicize information on the various programs that involve males. *	Male & Teen
Infrastructure Building Services	I	Provide training for providers in public health offices (clerks, office staff, etc.) to get males into family planning services. *	Male & Teen
Infrastructure Building Services	I	Use an economic cost-effectiveness argument to support male-oriented prevention efforts versus detention centers. *	Male & Teen
Infrastructure Building Services	I	Establish a commission on fatherhood.	Male & Teen
Infrastructure Building Services	I	Explore how to fund male involvement programs and services.	Teen

Table C. Recommendations on Access to and Use of Health Care, Health Insurance & Coverage

Pyramid Level	District	Current Capacity Activities Identified	MCH Population Group
Infrastructure Building Services	I	Set up a central clearinghouse to provide information on programs and resources for men and boys.	Male & Teen
Infrastructure Building Services	I	Using the concept of “rites of passage,” develop a strategy to put more emphasis in programs on male needs.	Teen
Infrastructure Building Services	I	Focus on primary prevention for males.	Male & Teen
Infrastructure Building Services	II	Replicate South Valley (Albuquerque) Male Involvement Project. *	Teen
Infrastructure Building Services	II	Develop service learning program in the District II public health offices/clinics to provide the opportunity for youth to learn about public health as a possible career; Title X funds for male involvement could fund stipends for men to do health internships both during the school year and in summer. *	Teen
Infrastructure Building Services	II	Add a requirement to NM Department of Health requests for proposals that respondents describe how they will involve and reach men and potential fathers. *	Male & Teen
Infrastructure Building Services	II	Assign a point person in the NM Department of Health, District II, who will be responsible for addressing male involvement in health programs.	Male & Teen
Infrastructure Building Services	II	Set up a central clearinghouse to provide information on programs/activities for men and boys.	Male, Child & Teen
Infrastructure Building Services	II	Recruit male health promotion staff for the Primeros Pasos program to attract male clients since this program is run by females.	Male & Teen
Infrastructure Building Services	II	Get the Santa Fe Health Planning and Policy Commission to consider male involvement in an upcoming policy review.	Male & Teen

Table C. Recommendations on Access to and Use of Health Care, Health Insurance & Coverage

Pyramid Level	District	Current Capacity Activities Identified	MCH Population Group
Infrastructure Building Services	II	Involve faith communities in addressing male involvement through ecumenical efforts.	Male & Teen
Infrastructure Building Services	II	Provide training for athletic coaches on “being a good role model.”	Child & Teen
Infrastructure Building Services	II	Focus on gender reconciliation and not just one gender or the other since the need is to strengthen families.	All
Infrastructure Building Services	IV	Create a central repository and forum for information on male involvement and related programs. *	Male & Teen
Infrastructure Building Services	IV	Replicate existing good models such as the Young Father’s Project and the South Valley (Albuquerque) Male Involvement Project. *	Teen
Infrastructure Building Services	IV	Assign a staff person in the Family Health Bureau as a point person who deals with men’s and boy’s issues.	Male, Child & Teen

Table D. Number of Recommendations on Access to and Use of Health Care, Health Insurance and Coverage

Population Group	Direct				Enabling				Population				Infrastructure			
	District I	District II	District III	District IV	District I	District II	District III	District IV	District I	District II	District III	District IV	District I	District II	District III	District IV
Pregnant Women & Mothers					1	1			1				1	3		
Infants													2	1		
Children					1								2	1		1
CYSHCN													1	1		
Teens					1	1			1				2	1		1
Males					1	1			1					1		
All		1			1							1	4	4	6	6

II.B.4.3 a-d Transition for Youth with Special Health Care Needs

MCH Program Capacity and Related Recommendations

During the MCH Needs Assessment workshops, 28 services were cited that describe capacity for one population group, CYSHCN, in New Mexico. Most of these services (17 citations) were enabling; others were infrastructure building (9), and one citation each was direct and population based. (See Table A, Sheet C3 for a detailed description of program capacity; Table B, Sheet CC3 for a count of program capacity citations; Table C, Sheet R3 for a detailed description of recommendations; and Table D, Sheet RC3 for a count of recommendations.)

Direct Health Care Services

Program Capacity was cited only by District II and referred to Villa Therese Catholic Clinic in Santa Fe.

Recommendations (none cited)

Enabling Services

Program Capacity was cited for Districts I, II and IV (only one service in District IV). District I cited both public and private sources of transition assistance for youth with special health care needs. Those cited include: public schools in Albuquerque and Belen that have youth in transition programs; Department of Labor's Division of Vocational Rehabilitation (DVR) that covers testing, schooling and medications; La Buena Vida non-profit that provides a "back door" to mental health counseling for children on a fee-for-service basis in Sandoval, Cibola, and Valencia counties; UNM and TVI that collaborate on special programs and scholarships; and private businesses (e.g., McDonalds and Burger King) that provide training and jobs. CMS and its social workers also help find private funding for CYSHCN serving as a bridge between age 18 (end of Medicaid eligibility) and age 21.

District II cited nine transition activities that demonstrate current capacity. Some are similar to those cited in District I such as school-based transition programs. High schools in Santa Fe and Las Vegas have career centers supported by the Department of Labor. These schools and also the Santa Fe Indian School and the NM School for the Deaf in Santa Fe sponsor career fairs. The DVR provides services in Espanola, Las Vegas, Santa Fe, and Taos; staff is committed and will visit schools. Follow-up with students, important for successful transition, is considered good in Espanola. The State has four one-stop career centers that provide multiple services, and one is in Santa Fe. Private sector/non-profit groups have transition activities in District II including: New Vistas that provides employment services and works with families of children with special needs in Santa Fe and Las Vegas; Catholic Charities that has a sliding scale for counseling;

Ayudante that provides counseling for substance abuse, and Challenge NM that serves individuals with developmental disabilities. CMS has a “TIPS” booklet on transition issues for teens, and a CSM intern is preparing a manual on scholarships for CYSHCN. CMS also provides copies of a CDC booklet on visits to doctors for CYSHCN.

District IV cited a CMS-supported *peer mentorship pilot program* that involves 10 peer meetings and school transition activities such as special education and counseling and involvement of the school nurse.

Recommendations were for all four districts, but most of the 17 citations were for District III (7 citations) and District IV (9 citations).

In District I:

- Disseminate *NM Youth Transition Resource Directory* (2002).

In District II:

- Create a transition assessment tool to help planning for CMS clients starting at age 14; this tool should be in English and Spanish and have a section for immigrant youth.

In District III, three recommendations involve information, education and communication (IEC) on transition issues:

- Set up a 1-800 number on transition issues/questions.
- Add a web page on transition to the NM Department of Health website and a chat room for parents.
- Reach out to parents to discuss transition issues starting when children are age ten.
- Publicize job fairs by giving flyers to high schools, local libraries, public service announcements (PSAs) on the radio.
- Use life skills curriculum in middle and high schools.
- Encourage shadowing at the workplace (“Take Your Child to Work Day”).

In District IV, the recommendations concern:

IEC on transition issues:

- Use transition video to educate the public, schools, and employers about youth transition.
- Develop “transition digest” listserv newsletter. Inform teens about CMS.
- Inform teens about CMS.

Planning/coordination

- Use as a resource the data base of young people interested in transition issues from the transition questionnaire.
- Work with parents and young people/children prior to age 14; begin transition planning in an age-appropriate manner as soon as diagnosis is made. *

- Provide better education for planning for independence with social worker (MSW) staff support.
- Provide realistic/encouraging career counseling with vocational rehabilitation staff and others.
- Increase CYSHCN program ties with the schools, particularly with the Individual Education Plan through Special Education, with the school nurse for medical issues, and with teachers, as needed.
- Provide better transition with specialist medical providers.

Population Based Services, only one and cited only in District IV:

- De-stigmatize illness and disability.

Infrastructure Building Services

Program Capacity was cited in all districts. District I cited UNM's Center for Disabilities that provides the full continuum of care and has medical champions throughout the state although it is considered underutilized. The Navajo Nation's transition program is in the Navajo DVR. In District II, the Healthy NM Transition Coordinating Council includes community programs in northern NM and is just starting to address transition issues for CYSHCN. District III cited four services including CMS, Behavioral Health, TRESCO (Doña Ana County employer) that work with the county schools, and Life Quest that serves youth and adults in a four-county area. District IV cited the Transition Coordinating Council, which has received a train-the-trainer Champions Grant; and CMS has developed a transition questionnaire to be administered to youth at age 14 during intake or renewal visits.

Recommendations were cited by all four districts.

In District I,

- Increase utilization of UNM's Center for Disabilities (it provides continuum of care and has medical champions throughout the state) since it could be a greater resource for transition issues for CYSHCN.

In District II, the recommendations were of two types:

Coordination and communication among agencies:

- Strengthen the liaison between CMS and schools regarding transition. *
- Improve partnerships among Division of Vocational Rehabilitation, CMS, and schools.
- Get word out that CMS Seeks people for mentorships and apprenticeships for CYSHCN.

Resources (program and funding):

- Expand training programs and resources available to all children and immigrants including CYSHCN.
- Increase resources for federally-funded health care clinics to include mental health, dental services, and medical care.
- Address barriers with sliding fee scale at clinics for youth with limited funds.

In District III, the recommendations were of two types:

Planning and collaboration:

- Increase awareness among agencies/providers about transition issues.
- Involve the Department of Labor/Division of Vocational Rehabilitation (DVR) in transition planning and services.
- Foster collaboration between Public Education Department and the NM Department of Health to help youth apply for the Developmental Disabilities Waiver earlier.
- Approach programs such as Boys and Girls Clubs, 4-H, youth DWI program for possible involvement.

Information and data:

- Survey parents about needs
- Develop database on CYSHCN and transition.

In District IV, the Recommendations concern *program development* and *collaboration*

- Foster more involvement on local level with any on-going local transition program/activities.
- Have more involvement of school nurses and school resources.
- Expand transition to school-based social workers for administering the questionnaires and supporting young people.
- Increase attendance at Transition Council meetings. Adapt transition program for young people with mental and learning issues.
- Provide training and resource sharing.

Constraints/Barriers related to transition for youth with special health care needs were cited in all four districts. Of 33 citations, District I had eight, District II had five, District III had three, and District IV had the most with 17.

In District I,

- Many needy families don't qualify for coverage of CYSHCN given CMS safety net at 200% of poverty level.
- If children aren't well managed in outpatient care, they may end up being hospitalized.
- Transition of CYSHCN from family-oriented care to adult specialists is difficult.
- Finding jobs and health insurance is difficult for youth in general and even harder for CYSHCN
- Mental health care is probably most difficult area to meet needs.
- UNM has no special plan for CYSHCN
- Torrance and Valencia counties do not have access to the reduced cost of UNM health care. Access is special problem for those with conditions such as diabetes and asthma that require medicine but who are not very disabled
- Some CYSHCN, who are mainstreamed in public schools, should be in more focused, residential settings.

In District II,

- CYSHCN who are 19 years old and over are not eligible for care and lack their own financial resources.
- Federally-qualified health clinics for CYSHCN are not providing mental health care, and some counseling is provided (based on a sliding scale for income) but no medications are covered. Even with sliding scale fees, some patients have difficulty paying for services.
- Rural areas do not have services, and there is a misconception that all District II patients live near medical facilities. Also, the current high cost of gasoline is a transportation barrier to accessing health services.
- Access to care is limited by a lack of transportation and Medicaid eligibility regulations.
- Access to care is also a problem for mental health conditions and other conditions not considered serious enough.
- Youth in transition need a social security number and a Development Disability waiver.

In District III, the barriers cited are:

- Public perception is that there isn't much a problem with youth in transition; this is especially true if the disability is not obvious.
- Providers are not very informed about the transition needs of youth with special health care needs.
- Vacant CMS position.

In District IV, some constraints and barriers are similar to those already cited for other districts.

- Lack of transition councils in districts.
- Specialists generally do not help clients with transition issues.
- Children and young people outside CMS do not have support for health issues and transition.
- A lot of activities for youth start after age 14, which is too late, for good transition planning.
- Poor communication between specialists and primary care physicians.
- There is a need to help young people in transition who have mental health issues and/or learning disabilities.
- *Funding issues:*
- Lack of jobs and lack of insurance for young people with chronic illnesses.
- Insurance companies do not take people with pre-existing conditions.
- *Training issues*
- Lack of training of people doing transition.

- Without an Individualized Education Plan (IEP), there may poor or no communication with school nurse.

Data and information

- Education level of young people and parents may not allow understanding of language of questionnaire. Hard to get accurate answers.
- Primary care physicians in rural areas are generalists. Medical transition may not be difficult in rural areas, but making the change to an adult specialist is harder since young patients are no longer coddled; management of condition falls apart if not very carefully tended.

Table A. Program Capacity for Transition for Youth with Special Health Care Needs

Pyramid Level	District	Current Capacity by Activities Identified	MCH Population Group
Direct Services	II	Villa Therese Catholic Clinic	CYSHCN
Enabling Services	I	Albuquerque Public Schools (APS) has a youth in transition program with case managers.	CYSHCN
Enabling Services	I	CMS and its social workers help find funding for children with medical needs and serve as a bridge from Medicaid after age 18 until age 21.	CYSHCN
Enabling Services	I	Division of Vocational Rehabilitation is a favorite resource since it covers testing, schooling, and medications.	CYSHCN
Enabling Services	I	Belen has a school-based program on transition and CYSHCN.	CYSHCN
Enabling Services	I	La Buena Vida, non-profit program, provides mental health counseling on a fee-for-service basis at offices in Sandoval, Cibola, and Valencia counties. It is a "back door" to such services for some children.	CYSHCN
Enabling Services	I	UNM and TVI have special programs, scholarships, and other assistance for youth with special needs.	CYSHCN
Enabling Services	I	Private business (McDonalds, Burger King, and Wal-Mart) provides training and jobs for youth with special needs. Adelante provides training and links to such jobs.	CYSHCN
Enabling Services	II	CMS has two pilot projects on transition issues. One is a training program on transition and CYSHCN to build capacity for mentorships that would pair a college student with special health care needs (SHCN) with high school students with SHCN. The pilot involves Highlands University and East Las Vegas High School. The second is a film that is being developed for youth, families, and community partnership that will feature youth with SHCN. In addition, there is a newsletter and website for CMS staff and medical providers that provide information on CYSHCN resources.	CYSHCN
Enabling Services	II	Schools have transition programs, e.g. Federally-funded disability program provides colleges with grant support for mentorships. Also, high schools have career centers (in Santa Fe and Las Vegas) that are supported by the Dept of Labor. Schools also sponsor career fairs (in Santa Fe and Las Vegas this year). The Indian School in Santa Fe and the NM School for the Deaf also have career fairs.	CYSHCN

Table A. Program Capacity for Transition for Youth with Special Health Care Needs

Pyramid Level	District	Current Capacity by Activities Identified	MCH Population Group
Enabling Services	II	Division of Vocational Rehabilitation of the Dept. of Labor provides services in Las Vegas, Santa Fe, and Taos. DVR staff is committed and will go to schools. Follow-up with school students is important for success and is considered good in Espanola and could be better in Santa Fe. There are currently four career one-stop centers that provide multiple services, one of which is in District II (Santa Fe), and the goal is to have 12 centers in the State.	CYSHCN
Enabling Services	II	A CMS intern is preparing a manual on scholarships for CYSHCN.	CYSHCN
Enabling Services	II	CMS has a "TIPS" booklet on transition issues for teens, and CDC has a booklet on visits to doctors and CYSHCN.	CYSHCN
Enabling Services	II	New Vistas (with offices in Santa Fe and Las Vegas) provides employment services and works with individuals with disabilities and families of children with special needs.	CYSHCN
Enabling Services	II	Catholic Charities offers a sliding fee scale for counseling.	CYSHCN
Enabling Services	II	Ayudante provides counseling for substance abuse.	CYSHCN
Enabling Services	II	Challenge NM provides services for individuals with developmental disabilities.	CYSHCN
Enabling Services	IV	Peer mentorship pilot program – CMS activities - case by case; ten peer meetings; school transition activities (special ed/counseling; school nurse).	CYSHCN
Population Based Services	IV	Video outreach.	CYSHCN
Infrastructure Building Services	I	UNM Center for Disabilities [Continuum of Care] has medical "champions" throughout the state and is an underutilized resource for transition issues for CYSHCN.	CYSHCN
Infrastructure Building Services	I	Navajo Nation transition program is in Navajo Vocational Rehabilitation Division.	CYSHCN
Infrastructure Building Services	II	There is a Healthy NM Transition Coordinating Council that includes community programs in Northern NM. The Council is just starting to get involved in these issues.	CYSHCN

Table A. Program Capacity for Transition for Youth with Special Health Care Needs

Pyramid Level	District	Current Capacity by Activities Identified	MCH Population Group
Infrastructure Building Services	III	Children's Medical Services.	CYSHCN
Infrastructure Building Services	III	TRESCO (a Dona Ana County employer), Life Quest (serves youth and adults in four county area) and other programs.	CYSHCN
Infrastructure Building Services	III	Behavioral Health provides services to children with special health care needs.	CYSHCN
Infrastructure Building Services	III	Doña Ana schools have a collaboration with TRESCO for some services.	CYSHCN
Infrastructure Building Services	IV	CMS transition questionnaire at age 14 – to be administered at CMS intake or renewals.	CYSHCN
Infrastructure Building Services	IV	Transition Coordinating Council received a train the trainer grant (Champions Grant) that will begin; Transition Council Workshop.	CYSHCN

Table B. Number of Program Capacity Citations for Transition for Youth with Special Health Care Needs*

Population Group	Direct				Enabling				Population				Infrastructure			
	District I	District II	District III	District IV	District I	District II	District III	District IV	District I	District II	District III	District IV	District I	District II	District III	District IV
Pregnant Women & Mothers																
Infants																
Children																
CYSHCN		1			7	9		1				1	2	1	4	2
Teens																
Males																
All																

Table C. Recommendations on Transition for Youth with Special Health Care Needs*

Pyramid Level	District	Recommendations Cited at MCH Needs Assessment Workshops	MCH Population Group
Enabling Services	I	Disseminate information on NM Youth in Transition Resource Directory (2002) for families and children.	CYSHCN
Enabling Services	II	Create a transition assessment tool to help planning for CMS clients starting at age 14; this tool should be in English and Spanish and have a section for immigrant youth.	CYSHCN
Enabling Services	III	Set up a 1-800 number on transition issues/questions. *	CYSHCN
Enabling Services	III	Add a web page on transition to the NM Department of Health website and a chat room for parents. *	CYSHCN
Enabling Services	III	Reach out to parents to discuss transition issues starting when children are age ten.	CYSHCN
Enabling Services	III	Publicize job fairs by giving flyers to high schools, local libraries, PSAs on the radio.	CYSHCN
Enabling Services	III	Use life skills curriculum in middle and high schools.	CYSHCN
Enabling Services	III	Encourage shadowing at the workplace ("Take Your Child to Work Day").	CYSHCN
Enabling Services	IV	Use data base of young people interested in transition issues from the transition questionnaire. *	CYSHCN
Enabling Services	IV	Work with parents and young people/children prior to age 14; begin transition planning in an age-appropriate manner as soon as diagnosis is made. *	CYSHCN
Enabling Services	IV	Develop "transition digest" listserv newsletter. *	CYSHCN
Enabling Services	IV	Provide better education for planning for independence with social worker (MSW) staff support.	CYSHCN
Enabling Services	IV	Provide realistic/encouraging career counseling with vocational rehabilitation staff and others.	CYSHCN
Enabling Services	IV	Use transition video to educate the public, schools, and employers about youth transition.	All
Enabling Services	IV	Inform teens about CMS.	CYSHCN

Table C. Recommendations on Transition for Youth with Special Health Care Needs*

Pyramid Level	District	Recommendations Cited at MCH Needs Assessment Workshops	MCH Population Group
Enabling Services	IV	Increase CYSHCN program ties with the schools, particularly with the Individual Education Plan through Special Education, with the school nurse for medical issues, and with teachers, as needed.	CYSHCN
Enabling Services	IV	Provide better transition with specialist medical providers.	CYSHCN
Population Based Services	IV	De-stigmatize illness and disability.	All
Infrastructure Building Services	I	Work with school based health centers to address transition and CYSHCN; get new centers to work on transition issue from the start; explore recommendations with the Office of School Health/NM Department of Health. *	CYSHCN
Infrastructure Building Services	I	Get CMS and Albuquerque Public Schools and other school districts to team up and involve school counselors and social workers. *	CYSHCN
Infrastructure Building Services	I	Form advisory group of youth in transition from different parts of state (including rural areas) to develop innovative approaches and a plan for transition. *	CYSHCN
Infrastructure Building Services	I	Explore potential of Association for Retarded Citizens which has a contract with Long Term Services Division/NM Department of Health to focus on the need for transition. *	CYSHCN
Infrastructure Building Services	I	Give more attention to children with behavioral and mental health problems,	CYSHCN
Infrastructure Building Services	I	Tap programs such as La Vida Felicidad, Job Corps, and others to help with transition.	CYSHCN
Infrastructure Building Services	I	Provide more funding for priority areas without taking funds from other programs.	CYSHCN

Table C. Recommendations on Transition for Youth with Special Health Care Needs*

Pyramid Level	District	Recommendations Cited at MCH Needs Assessment Workshops	MCH Population Group
Infrastructure Building Services	I	Increase utilization of UNM's Center for Disabilities (it provides continuum of care and has medical champions throughout the state) since it could be a greater resource for transition issues for CYSHCN. [moved from capacity on 6/20 & be sure to add throughout]	CYSHCN
Infrastructure Building Services	II	Strengthen the liaison between CMS and schools regarding transition. *	CYSHCN
Infrastructure Building Services	II	Improve the Division of Vocational Rehabilitation, CMS, and schools partnership. *	CYSHCN
Infrastructure Building Services	II	Expand training programs and resources available to all children and immigrants including CYSHCN. *	CYSHCN
Infrastructure Building Services	II	Increase resources for federally-funded health care clinics to include mental health, dental services, and medical care. *	CYSHCN
Infrastructure Building Services	II	Address barriers with sliding fee scale at clinics for youth with limited funds. *	CYSHCN
Infrastructure Building Services	II	Get word out that CMS Seeks people for mentorships and apprenticeships for CYSHCN.	CYSHCN
Infrastructure Building Services	III	Increase awareness among agencies/providers about transition issues. *	CYSHCN
Infrastructure Building Services	III	Involve the Department of Labor/Division of Vocational Rehabilitation (DVR) in transition planning and services. *	CYSHCN
Infrastructure Building Services	III	Develop database on CYSHCN and transition.	CYSHCN

Table C. Recommendations on Transition for Youth with Special Health Care Needs*

Pyramid Level	District	Recommendations Cited at MCH Needs Assessment Workshops	MCH Population Group
Infrastructure Building Services	III	Survey parents about needs.	CYSHCN
Infrastructure Building Services	III	Foster collaboration between Public Education Department and the NM Department of Health to help youth apply for the Developmental Disabilities Waiver earlier.	CYSHCN
Infrastructure Building Services	III	Approach programs such as Boys and Girls Clubs, 4-H, youth DWI program for possible involvement.	CYSHCN
Infrastructure Building Services	IV	Foster more involvement on local level with any on-going local transition program/activities. *	CYSHCN
Infrastructure Building Services	IV	Have more involvement of school nurses and school resources. *	CYSHCN
Infrastructure Building Services	IV	Expand transition to school-based social workers for administering the questionnaires and supporting young people.	CYSHCN
Infrastructure Building Services	IV	Increase attendance at Transition Council meetings.	CYSHCN
Infrastructure Building Services	IV	Adapt transition program for young people with mental and learning issues.	CYSHCN
Infrastructure Building Services	IV	Provide training and resource sharing.	CYSHCN

Table D. Number of Recommendations on Transition for Youth with Special Health Care Needs

Population Group	Direct				Enabling				Population				Infrastructure			
	District I	District II	District III	District IV	District I	District II	District III	District IV	District I	District II	District III	District IV	District I	District II	District III	District IV
Pregnant Women & Mothers																
Infants																
Children																
CYSHCN					1	1	6	8					8	6	6	6
Teens																
Males																
All								1				1				

II.B.4.4.a-d Preconception and Prenatal

MCH Program Capacity and Related Recommendations

During the Needs Assessment workshops, 61 services were cited that describe capacity for preconception and prenatal health care in New Mexico. Most of these services were enabling (26 citations) or infrastructure building services (20 citations). Ten citations were for population based services, and five were for direct services. In terms of population groups, 58 citations (all but three) concern pregnant women, mothers, and teens; two citations were for males, and one was for CYSHCN. (See Table A, Sheet C4 for a detailed description of program capacity; Table B, Sheet CC4 for a count of program capacity citations; Table C, Sheet R4 for a detailed description of recommendations; and Table D, Sheet RC4 for a count of recommendations.)

Direct Health Care Services

Program Capacity was cited by Districts III and IV. La Clinica de la Familia (District III) and Lea County Health Office (District IV) provide prenatal services for pregnant women and teens. Chaves County's indigent fund covers prenatal care. School-based Health Centers serve teens in numerous school districts such as Clovis, Dexter, Hobbs, Hagerman, Santa Rosa, and Tucumcari. Health centers serve college students at Roswell and Portales campuses of Eastern NM University.

Recommendations were cited in Districts III and IV. Each district cited one recommendation, which was similar: restore county MCH funds for direct "safety net" services and for enabling services such as care coordination, home visits, and transportation.

Enabling Services

Program Capacity was cited for all four districts. In District I, family planning clinics, school-based health centers, WIC, and Families First provide education opportunities on preconception and prenatal issues. In District II, Presumptive Eligibility for Medicaid (PEMOSSA) was cited, which supports access to family planning services and prenatal care. In District III, Graduation Reality and Dual-role Skills program (GRADS) in Socorro is an in-school program serving pregnant and parenting teens. In Dona Ana County, La Clinica de la Familia and the public health service provide outreach and home visiting by promotoras and serve as a link between prenatal care, delivery, and postnatal care. Head Start in Las Cruces has a community resource director and is a good link for health staff and communities.

District IV had 15 citations, mostly in Chaves County (site of the Needs Assessment workshop) covering a range of services including:

- Prevention education, e.g., a school-based abstinence-only curriculum
- MCH project office is open 8 am-5 pm, every weekday and provides education (uses part of a Lifelong Happiness curriculum), smoking session, home visits. It fills a gap for indigents and other not covered by health insurance.
- In Chaves and Eddy (town of Artesia) counties, Families First (a statewide program) was cited as serving only those eligible for Medicaid and does home visiting.
- Court-ordered parenting programs in Carlsbad (Eddy County), Clovis (Curry County), and Roswell (Chaves County) through the Roswell-based private firm, Counseling Associates.
- Church-based services including the Chaves County Pregnancy Resource Center with supports groups for mothers and fathers, and the Presbyterian Minority Outreach Center, Roswell Refuge Shelter for battered adults and children serving Chaves and Lincoln counties, and Casa del Nuevo Comienzo (*house of the new beginning*) a residence program for pregnant, battered and homeless teens.

Recommendations were cited in all four districts.

In District I,

- Reprint and use existing preconception assessment and education tool.

In District II,

Continue provision of community based mental health services in Las Vegas.

Provide anger management in schools; implementation of a two-hour session that would have high pay-off.

In District III,

- Get word out that First Steps, a prenatal-perinatal care provider, is back in business in Las Cruces and does deliveries (midwives at Memorial Medical Center).
- Use materials from Title X family planning on forming healthy relationships for work with youth.
- Use abstinence-only education (6th grade and below) as a vehicle for education on preconception issues.

In District IV,

Start preconception education at middle school level for both boys and girls.

Use the already developed preconception health screening and counseling tool in health fairs and in addition to folic acid education, add smoking and alcohol education.

Provide housing for homeless pregnant women over twenty-one.

Strengthen family relationships
Conduct parenting classes through churches and other organizations.

Population Based Services

Program Capacity was cited in two districts. In District II, the Violence, Alcohol, Substance and Tobacco (VAST) screening program is an important first step, and the program is beginning to help find services (although there are not many referral services) for people who need to be referred for additional health care. In District IV, the Chaves County Health Office has family planning clinics that provide preconceptional folic acid and prenatal vitamins teens at risk of pregnancy. Other Chaves County providers of pre-natal care and screening for family abuse include La Casa, Family Practice Residency Center, and Sage Ob/Gyn practice. With funding from the Tobacco Use Prevention and Cessation Program, the MCH Project staff is trained and conducts smoking session programs for teens and adults; clients can get free gum, patches, etc. from local pharmacies in Chaves and Eddy counties. The Curry County Health Council, with funding from the March of Dimes, sponsors health fairs in Clovis and provides preconception information including on folic acid.

Recommendations (none cited)

Infrastructure Building Services

Program Capacity was cited in all districts. District I cited the Health Commons model in Sandoval County, which is an inter-agency, public/private partnership, providing a multi-disciplinary team for family-based support. The public health offices are collecting health histories on clients' medical charts, and Families First and WIC share databases to improve referrals and client care based on a memorandum of agreement to share WIC information. District II cited school-based health centers that are in seven of the eight district counties as being a big accomplishment for public health nurses and that the quality of care is much improved. CMS social workers serve CYSHCN, and the Santa Fe Health Council works to address the needs of immigrants. Las Vegas will be opening a new domestic violence shelter.

District III cited the strong MCH cadre of personnel even though there is considerable variation in funding and services across the eight counties in the District. The Border Epidemiology Center (a technical center of the Office of Border Health at NM State University) compiles information on border health councils, projects, and publications and provides data for local groups. District IV cited Chaves County Prenatal Care Network that assures that all women in the county (regardless of their ability to pay) receive care and the UNM Family Practice Residency Center that provides prenatal care

and hospital delivery. In Lea County, an assessment and counseling tool was developed under a research and counseling project on preconception (a project that is no longer funded).

Recommendations were cited in all four districts.

In District I, the three recommendations concern: more funding for case management, new community partners as additional resources, data management and use (user-friendly information system across MCH programs).

In District II, the nine IBS recommendations are related to improving providers' skills, addressing the health needs of adults (for disease prevention and treatment (e.g. of diabetes), using existing service delivery models (e.g. Families FIRST, S-BIRT (Screen, Brief intervention, referral and Treatment) and promotoras) to improve services such as mental health and to expand community access to services.

In District III, the five IBS recommendations are:

- Integrate preconception issues into Title X activities including in school (6th grade and up) and reformulate health education objectives to accommodate this recommendation.
- Add a preconception clause into the county MCH contracts of the county or community health councils in order to improve preconceptional health.
- Expand health promotion programs to include preconception and prenatal care and get health promotion teams to target communities to demonstrate the impact of this care.
- Explore a role for faith-based communities in prenatal care.
- Use concepts of social assets and resiliency factors (e.g. connectedness to families, schools, and communities) to emphasize how they can protect youth from risk-taking behaviors, and use information and data from the NM Youth Risk and Resiliency Surveys to build on positive assets for youth.

In District IV, three recommendations concern expanding programs (e.g. home visiting and support groups for mothers and fathers) as well as advocacy (using available program data and evidence to get preconception health on the agenda of leaders and many interested groups).

Constraints/Barriers related to preconception and prenatal services were cited (13 total) in all four districts. District I cited limited funding, limited staff time to partner, and that staff resources were not adequate to meet the need for services.

In District II, the two barriers cited are:

- Most people are unaware of the U.S. Department of Health and Human Services' guidelines for low-risk preconceptional and prenatal behavior including alcohol use.

In District III, the five recommendations cover different levels of service. In terms of direct services, prenatal care is not provided at Socorro's public health office, and there were 25 undocumented women who delivered babies in Sierra County. Of enabling services, there were two constraints cited:

- Lack of funding for transporting clients to services in the more rural counties of the district.
- Lack of parent-child (especially teens) communication, which is a generic problem everywhere in the country and not only in New Mexico.

On infrastructure building, the one citation is:

- Lack of funding for health education in schools.

Community Strengths and Resources

District I cited committed community health workers as the one important asset for preconceptional and prenatal issues. District II cited a similar asset, which is the strength of the Public Health Division (PHD), highlighting the respect and trust that the public has with PHD nurses, physicians, social workers, and others.

Table A. Program Capacity for Preconception and Prenatal

Pyramid Level	District	Preconception and Prenatal: Current Capacity Activities Identified	MCH Population Group
Direct Services	III	La Clinica de la Familia provides prenatal services.	Maternal & Teen
Direct Services	IV	Prenatal services are offered in the Lea County Health Office.	Maternal & Teen
Direct Services	IV	School-based Health Centers provides services in Roswell, Hagerman, Dexter, Eastern New Mexico University/Roswell and Portales campuses, Clovis High School, Tucumcari High School, Santa Rosa High School, and Hobbs High School.	Teen
Enabling Services	I	School-based health clinics, family planning clinics, WIC, and Families First provide teaching opportunities on preconception and prenatal issues.	Maternal & Teen
Enabling Services	II	Access to Prenatal Care and Family Planning services through PEMOSSA (Presumptive eligibility for Medicaid).	Maternal & Teen
Enabling Services	III	Doña Ana County has an outreach and home visiting program using promotoras.	Maternal & Teen
Enabling Services	III	La Clinica de la Familia has promotoras who are the connection between prenatal care, delivery, and postnatal care.	Maternal & Teen
Enabling Services	III	GRADS Program in Socorro is active and provides an in-school program for pregnant and parenting teens.	Teen
Enabling Services	III	Head Start has a community resource director and is a good link for health staff and communities.	Maternal & Teen
Enabling Services	IV	In Chaves County, MCH Project is open 8-5, five days a week and provides education, home visiting, smoking cessation; fills gaps for indigent and others not covered by health insurance. It also offers case management and home visiting (served 274 clients).	Maternal & Teen
Enabling Services	IV	Families FIRST serves Medicaid eligibles only, and the program provides home visiting. Families FIRST in Artesia does a high rate of home visits.	Maternal & Teen
Enabling Services	IV	Chaves County indigent fund covers prenatal care.	Maternal & Teen
Enabling Services	IV	Chaves County Pregnancy Resource Center provides mother and father support groups (church based organization).	Maternal, Male & Teen

Table A. Program Capacity for Preconception and Prenatal

Pyramid Level	District	Preconception and Prenatal: Current Capacity Activities Identified	MCH Population Group
Enabling Services	IV	People are referred to the Refuge (battered women's shelter) Presbyterian Minority Outreach Center. Casa Nuevo Comienzo is a residence with room for pregnant, battered and homeless teens.	Maternal & Teen
Enabling Services	IV	Some court ordered parenting programs are available through Counseling Associates in Roswell and also in Clovis and Carlsbad.	Maternal, Male & Teen
Enabling Services	IV	The MCH Project in Chaves County uses part of the Life Long Happiness curriculum, although the curriculum is too long to be used fully.	Maternal & Teen
Enabling Services	IV	Roswell Independent School District has an abstinence education grant for high school.	Teen
Population Based Services	II	Violence, Alcohol, Substance & Tobacco (VAST) screening was an important first step. There are some services where people can be referred, but this continues to be a need and now the program is moving to finding services for people who need them.	Maternal & Teen
Population Based Services	IV	The Chaves County Health Office has family planning clinics that provide prenatal vitamins for teens at risk of a pregnancy and assure preconceptional use of folic acid.	Teen
Population Based Services	IV	In Clovis, health fairs are held that provide preconceptional information including folic acid, and are sponsored by the Curry County Health Council and funded by the March of Dimes.	Maternal & Teen
Population Based Services	IV	In Chaves County, smoking cessation for teen and adults through the MCH Project is funded by TUPAC (Tobacco Use Prevention and Cessation Program) of the DOH). MCH Project staff is trained; clients can get free gum, patch, etc. from local pharmacies in Chaves and Eddy Counties.	Maternal, Male? & Teen
Population Based Services	IV	Some Chaves County providers of prenatal care conduct screening for family abuse. These providers include La Casa, the Family Practice Residency Center, Sage Ob-Gyn practice, and maybe midwives.	Maternal & Teen
Infrastructure Building Services	I	Health Commons model in Sandoval county is an interagency, public/private partnership and provides a multi-disciplinary team for a family-based support program.	Maternal & Teen

Table A. Program Capacity for Preconception and Prenatal

Pyramid Level	District	Preconception and Prenatal: Current Capacity Activities Identified	MCH Population Group
Infrastructure Building Services	I	Families FIRST and WIC share databases to enhance referrals and client care. They have a memorandum of agreement to share/obtain WIC information.	Maternal & Teen
Infrastructure Building Services	I	All public health offices are collecting health histories on clients' medical charts.	Maternal & Teen
Infrastructure Building Services	II	Las Vegas is getting a new domestic violence shelter.	Maternal & Teen
Infrastructure Building Services	II	School-based Health Centers are in seven out of nine counties in the district; big accomplishment of public health nurses; quality of visits much greater.	Teen
Infrastructure Building Services	II	Social workers in CMS serve CYSHCN.	CYSHCN
Infrastructure Building Services	II	Santa Fe Health Council works to address health care needs for immigrants.	Maternal & Teen
Infrastructure Building Services	III	Strong MCH cadre of personnel in District III although there is much variation in funding and services.	Maternal & Teen
Infrastructure Building Services	III	Border Epidemiology Center, a technical center of the Office of Border Health, NMSU, compiles information on border health councils, projects, and publications and can provide data to local groups. See www.nmborderhealth.com.	Maternal & Teen
Infrastructure Building Services	IV	Chaves County Prenatal Care Network assures that all women in the county, regardless of ability to pay, can receive prenatal care. The UNM Family Practice Residency Center provides prenatal care and then hospital delivery.	Maternal & Teen
Infrastructure Building Services	IV	A preconceptional research and counseling project was previously funded in Lea County; needs to be funded again. An assessment and counseling tool was developed and could be used again.	Maternal & Teen

Table B. Number of Program Capacity Citations for Preconception and Prenatal*

Population Group	Direct				Enabling				Population				Infrastructure			
	District I	District II	District III	District IV	District I	District II	District III	District IV	District I	District II	District III	District IV	District I	District II	District III	District IV
Pregnant Women & Mothers			1	1	1	1	3	7		1		3	3	2	2	2
Infants																
Children																
CYSHCN														1		
Teens			1	2	1	1	4	7		1		4	3	3	2	2
Males								1				1				
All																

Table C. Recommendations on Preconception and Prenatal

Pyramid Level	District	Recommendations Cited at MCH Needs Assessment Workshops	MCH Population Group
Direct Services	III	Restore funding for county MCH, especially for direct services such as care coordination, home visiting, and transportation. *	Maternal & Teen
Direct Services	IV	Continue to assure County MCH funding for direct services, particularly key services that are a safety net. *	Maternal & Teen
Enabling Services	I	Reprint and use existing preconception assessment and education tool. * (I)	Maternal & Teen
Enabling Services	II	Continue provision of community based mental health services in Las Vegas. *	Maternal & Teen
Enabling Services	II	Provide anger management in schools; implementation of a two-hour session that would have high pay-off.	Child & Teen
Enabling Services	III	Get word out that First Steps, a prenatal-perinatal care provider, is back in business in Las Cruces and does deliveries (midwives at Memorial Medical Center).	Maternal & Teen
Enabling Services	III	Use abstinence-only education (6th grade and below) as a vehicle for education on preconception issues.	Child
Enabling Services	III	Use materials from Title X family planning on forming healthy relationships for work with youth.	Teen
Enabling Services	IV	Start preconception education at middle school level for both boys and girls. *	Child & Teen
Enabling Services	IV	Use the already developed preconception health screening and counseling tool in health fairs and in addition to folic acid education, add smoking and alcohol education. *	Maternal & Teen
Enabling Services	IV	Provide housing for homeless pregnant women over twenty-one.	Maternal
Enabling Services	IV	Strengthen family relationships.	Maternal, Male, Child & Teen
Enabling Services	IV	Conduct parenting classes through churches and other organizations.	Maternal, Male & Teen

Table C. Recommendations on Preconception and Prenatal

Pyramid Level	District	Recommendations Cited at MCH Needs Assessment Workshops	MCH Population Group
Infrastructure Building Services	I	Develop and share a user-friendly integrated information system across MCH programs. *	Maternal & Teen
Infrastructure Building Services	I	Support more case management. *	Maternal & Teen
Infrastructure Building Services	I	Find new partners in the community as resources. *	Maternal & Teen
Infrastructure Building Services	II	Use model from Las Vegas where a public health nurse and nurse from Las Vegas Medical Center are being trained as certified diabetes educators to create more certified diabetes educators in the district. *	Maternal & Teen
Infrastructure Building Services	II	Use disease prevention specialists to provide more adult services. *	Maternal & Male
Infrastructure Building Services	II	Expand public health social worker services beyond CMS/CYSHCN to address adult issues. *	Maternal & Male
Infrastructure Building Services	II	Provide more psychologist services to reach adult clients.	Maternal & Male
Infrastructure Building Services	II	Implement S-BIRT (screen, brief intervention, referral, and treatment) in Raton, Taos, and four school based health centers.	Maternal & Teen
Infrastructure Building Services	II	Use Families First as a good focus/model for interviewing skills and addressing mental health topics.	Maternal & Teen
Infrastructure Building Services	II	Improve emphasis on MCH issues in community/county health councils; MCH needs to be kept "alive and well."	All

Table C. Recommendations on Preconception and Prenatal

Pyramid Level	District	Recommendations Cited at MCH Needs Assessment Workshops	MCH Population Group
Infrastructure Building Services	II	Build on the promotora model to expand community access to other services, e.g. diabetes.	Maternal & Teen
Infrastructure Building Services	II	Train clinicians to develop effective skills and dialogue for working with VAST topics.	Maternal & Teen
Infrastructure Building Services	III	Integrate preconception issues into Title X activities including in school (6th grade and up); health education objectives need to be reformulated. *	Maternal & Teen
Infrastructure Building Services	III	Add a preconception clause into the County MCH contracts (county/community health councils) that directs effort at improving preconceptional health. *	Maternal & Teen
Infrastructure Building Services	III	Change focus of health promotion to include preconception and prenatal care and get health promotion teams to target communities to show consequences of such care.	Maternal & Teen
Infrastructure Building Services	III	Explore role for faith-based communities in prenatal care.	Maternal & Teen
Infrastructure Building Services	III	Use the concepts about social assets and how they can protect youth from risk-taking behaviors; use the data on assets to build on positive assets for youth.	Teen
Infrastructure Building Services	IV	Use available data as evidence to get preconception health on the action agenda/radar screen of many groups and leaders – 30% “healthy births” is not good enough for New Mexico. *	Maternal & Teen
Infrastructure Building Services	IV	Increase the availability of mother’s and father’s support groups.	Maternal, Male & Teen
Infrastructure Building Services	IV	Increase home visiting programs.	Maternal, Male & Teen

Table D. Number of Recommendations on Preconception and Prenatal*

Population Group	Direct				Enabling				Population				Infrastructure			
	District I	District II	District III	District IV	District I	District II	District III	District IV	District I	District II	District III	District IV	District I	District II	District III	District IV
Pregnant Women & Mothers	1			1	1	1	1	4					3	8	4	3
Infants																
Children						1	1	2								
CYSHCN																
Teens	1			1	1	2	2	4					3	5	5	3
Males								2						3		2
All														1		

II.B.4.5.a-d Male Involvement and Fatherhood

MCH Program Capacity and Related Recommendations

During the Needs Assessment workshops, 58 services were cited that describe capacity for male involvement and fatherhood. Over 80 percent (49 citations) were enabling services, and 9 were population based services. There were no citations designated as direct or infrastructure building services. The services benefited four population groups in rank order by number of citations: teens (30), children (14), males (11), and pregnant women and mothers (3). District III did not have a working group on this priority topic (there were not enough workshop participants to attend the breakout session on the topic), but there was one citation for enabling services on this topic. (See Table A, Sheet C5 for a detailed description of program capacity; Table B, Sheet CC5 for a count of program capacity citations; Table C, Sheet R5 for a detailed description of recommendations; and Table D, Sheet RC5 for a count of recommendations.)

Direct Health Care Services

Program Capacity (none cited)

Recommendations, only one was cited and only in District I:

- Increase access to emergency contraception.

Enabling Services

Program Capacity was cited for all districts. In District I (19 citations), Peanut Butter and Jelly Family Services provides parenting classes for pregnant women, males and teens who are prospective parents. A service for teens is Youth Build. Services for children and teens include mentoring programs, Media Literacy Project of UNM and Albuquerque Academy, the Charter School Alliance (Bernalillo County), a new program for dads and daughters (town of Los Lunas), and various traditional partners such as faith-based groups, sports clubs, 4-H, and Boy and Girl Scouts. Two model projects for males and teens were highlighted not only in District I but also in District II:

- ***Young Fathers Project of the NM Teen Pregnancy Coalition*** has a case load of about 100 young fathers a month. It serves young dads, works with the juvenile justice system, does intensive case management, assists in establishing paternity, and supports visitations by fathers, court advocacy, parenting classes, peer mentors, and teen pregnancy prevention. The Young Fathers project has services in several locations in the state including Albuquerque, Santa Fe, and Springer.

- ***South Valley Male Involvement Project***, funded by District I Health Promotion, selected its target population based on a zip code analysis to determine high-risk areas. It serves Hispanic men and boys, works with the Metro Detention Centers, and supports education sessions, media campaigns, and training for young parents. It also generates many referrals to appropriate helping agencies such as community mental health, HIV prevention, and family planning services.

District II (17 citations) has one citation that benefits children, the Santa Fe Trail Summer Program, which offers activities for boys and girls in Raton. Santa Fe Community College provides training for parents on childcare through its family-oriented community outreach programs. Services that benefit children and teens are:

- Georgia O’Keefe Museum has a summer program, O’Keefe Art and Leadership Program, for boys ages 11-13 to develop skills (decision making, independent thinking, problem solving) and creativity. High school and college interns assist in the program and serve as role models.
- Public Health Office and the County Health Council are working with the Big Brothers Big Sisters in Raton to develop a mentoring program.
- Many traditional programs such as 4-H, Boy Scouts, Girl Scouts, and sports clubs.

District II’s Public Health Office has a harm reduction team that visits and provides services to resident of the Santa Fe County Youth Detention Center. New Mexico Men’s Wellness supports many activities for males and teens that address male involvement. Men’s Resource Center of Northern New Mexico, based in Taos, has various programs to support men including help to overcome violent behavior and outreach to local schools on domestic violence prevention (benefiting males, children and teens).

A **model program** in-the-making is Early Head Start in Eddy County (District IV: city of Carlsbad has hired a male-involvement coordinator) and in Doña Ana, Hidalgo, Luna, Otero, and Sierra counties (District III). Early Head Start is working to involve fathers. In Doña Ana County, the program conducts parenting classes for pregnant women, and prospective fathers and teens parents.

District IV (11 citations) cited two services for children and teens: 4-H and Big Brothers, Big Sisters (Chaves County) that have a good program and more demand than it can accommodate so it maintains a waiting list. Programs for teens are:

- Juvenile Justice Action Committee funds and supports several programs, e.g., Casa, which provides “laid-back” mentoring and First Offenders, which provides mentoring.

- Venture Program, funded by the Roswell Police Athletic Association, sponsors activities for male youth.
- REACH program (Roswell) is working on youth empowerment.
- Unity Center for Youth (Roswell) produces and markets different handicraft and other products.

Recommendations were cited in two Districts.

In District I, there were five recommendations:

- Make public health offices more “male-friendly.”
- Overcome barriers to using male language.
- Take information and education to where men are (e.g., barbershops, bars).
- Hold a conference for young men to provide training, education, and support.
- Help small business to develop business plans to reach out to employable males.

In District II, there were two recommendations:

- Make public health offices/clinics more “male-friendly” (e.g., add posters with men, magazines for men).
- Get St. Vincent’s Hospital, Santa Fe to reach out more to males (e.g., prostate screening program, sessions on alcohol abuse prevention).

Population Based Services

Program Capacity was cited in three of four districts.

District I cited the increase in awareness of male issues due to the existence of program and the media attention they have received with benefits for teens, children, and men.

District II cited three programs that serve teens and men:

- Families First that is beginning to engage men and fathers in its work
- Child Abuse Prevention that is expanding to include fathers
- Las Cumbres Learning Services in Espanola that provides prevention and early intervention services including a teen fathers’ group.

District IV cited Boys and Girls Clubs that use Smart Moves curriculum on making good decisions benefiting children and teens. Mesalands College and Eastern New Mexico University (Ford Foundation grant) has an economic development project for teens and young people aimed at increasing access to education, especially vocational education.

Recommendations were cited only in District IV. The one recommendation is:

- Create greater awareness of the need for programs that focus on males and publicize information on the various programs that involve males.

Infrastructure Building Services

Program Capacity (none cited)

Recommendations were cited in three districts.

In District I, there were six recommendations.

- Establish a commission on fatherhood.
- Use an economic cost-effectiveness argument to support male-oriented prevention efforts versus detention centers.
- Provide training for providers in public health offices (clerks, office staff, etc.) to get males into family planning services.
- Explore how to fund male involvement programs and services.
- Set up a central clearinghouse to provide information on programs and resources for men and boys.
- Using the concept of “rites of passage,” develop a strategy to put more emphasis in programs on male needs.
- Focus on primary prevention for males.

In District II, there were 10 recommendations.

- Add requirement to NM Department of Health requests for proposals that respondents describe how they will involve and reach men and potential fathers.
- Assign a point person in the NM Department of Health, District II, who will be responsible for addressing male involvement in health programs.
- Set up a central clearinghouse to provide information on programs/activities for men and boys.
- Get the Santa Fe Health Planning and Policy Commission to consider male involvement in an upcoming policy review.
- Replicate South Valley (Albuquerque) Male Involvement Project.
- Develop a service learning program in the District II public health offices/clinics to provide the opportunity for youth to learn about public health as a possible career; Title X funds for male involvement could fund stipends for men to do health internships both during the school year and in summer.
- Recruit male health promotion staff for the Primeros Pasos program to attract male clients since this program is run by females.
- Involve faith communities in addressing male involvement through ecumenical efforts.
- Provide training for athletic coaches on “being a good role model.”

- Focus on gender reconciliation and not just one gender or the other since the need is to strengthen families.

In District IV, there three recommendations are:

- Assign a staff person in the Family Health Bureau as a point person who deals with men's and boy's issues.
- Create a central repository and forum for information on male involvement and related programs.
- Replicate existing good models such as the Young Father's Project and the South Valley (Albuquerque) Male Involvement Project.

Constraints/Barriers related to male involvement and fatherhood, only a total of three were cited in two Districts II and IV (no working groups were conducted in Districts I and III).

In District II,

- While male involvement is on the radar screen of the Health Council, it is not a priority.
- There is a growing number of single parent families with no male role model. The community has no plan to address this growing problem.

In District IV,

- It is difficult to work in some settings (e.g. the school board in Lincoln County did not permit Presbyterian Medical Services to offer a pregnancy and sexually-transmitted disease program in the schools).

Table A. Program Capacity for Male Involvement and Fatherhood

Pyramid Level	District	Current Capacity Activities Identified	MCH Population Group
Enabling Services	I	Young Fathers Project of NM Teen Pregnancy Coalition. The Project has a case load of about 100 per month; services young dads, works with the juvenile justice system, intensive case management, establishes paternity, supports: visitation by father, court advocacy, parenting classes, peer mentors, and teen pregnancy prevention.	Male & Teen
Enabling Services	I	South Valley Male Involvement Project, supported by District I Health Promotion, selected its target population based on zip code analysis. It services Hispanic men and boys, work with Metro Detention Center, and supports education sessions, media campaign, training for parents, and it generates many referrals to appropriate helping agencies.	Male & Teen
Enabling Services	I	Various traditional partners include faith-based groups, sports clubs, 4-H, and Boy Scouts.	Child & Teen
Enabling Services	I	Mentoring programs	Child & Teen
Enabling Services	I	Los Lunas is beginning a program for dads and daughters	Male, Child & Teen
Enabling Services	I	Youth Build	Teen
Enabling Services	I	Charter School Alliance in Bernalillo County	Child & Teen
Enabling Services	I	Media Literacy Project	Child & Teen
Enabling Services	I	Peanut Butter & Jelly Family Services provides parenting classes	Maternal, Male & Teen
Enabling Services	II	Young Fathers Project of the NM Teen Pregnancy Coalition in Santa Fe and Springer.	Teen
Enabling Services	II	Georgia O'Keefe Museum has a summer program, O'Keefe Art and Leadership Program for Boys ages 11-13 to develop skills (decision-making, independent thinking, problem solving, and creativity) and provide role models of high school and college interns.	Child & Teen

Table A. Program Capacity for Male Involvement and Fatherhood

Pyramid Level	District	Current Capacity Activities Identified	MCH Population Group
Enabling Services	II	Men's Resource Center of Northern New Mexico in Taos has various programs to support men including help to overcome violent behavior and outreach in local schools that focuses on preventing domestic violence.	Male, Child & Teen
Enabling Services	II	District II Public Health Office has a harm reduction team that visits and provides services to residents at the Santa Fe County Youth Detention Center.	Teen
Enabling Services	II	Santa Fe Community College provides training for parents in child-care among its family-oriented community outreach programs.	Male, Maternal & Teen
Enabling Services	II	In Raton, the Public Health Office and the Health Council is establishing a mentoring program with Big Brothers Big Sisters.	Child & Teen
Enabling Services	II	In Raton, the Santa Fe Trail Summer Program offers activities for boys and girls.	Child
Enabling Services	II	NM Men's Wellness supports many activities addressing male involvement. www.nmmenswellness.org.	Male & Teen
Enabling Services	II	Other traditional youth programs (4H Club, Boy Scouts, Girl Scouts, and sports clubs).	Child & Teen
Enabling Services	III	Head Start programs in Hidalgo, Luna, Otero, and Sierra counties are working to involve fathers; program in Doña Ana County has parenting classes.	Male & Teen
Enabling Services	IV	Head Start is doing work on fatherhood, giving parenting classes. Chapter in Carlsbad has male involvement coordinator.	Maternal, Male & Teen
Enabling Services	IV	The Venture program is funded by the Roswell Police Athletic Association and sponsors activities for male youth.	Teen
Enabling Services	IV	Big Brothers, Big Sisters in Chaves County (good program, more demand than can accommodate and has waiting list of youth).	Child & Teen
Enabling Services	IV	4-H	Child & Teen
Enabling Services	IV	Juvenile Justice Action Committee has funds and supports several programs (Casa provides laid-back mentoring; First Offenders provide mentoring).	Teen
Enabling Services	IV	REACH program in Roswell is working on empowerment of youth.	Teen

Table A. Program Capacity for Male Involvement and Fatherhood

Pyramid Level	District	Current Capacity Activities Identified	MCH Population Group
Enabling Services	IV	In Roswell, Unity Center for youth produces and markets products	Teen
Population Based Services	I	There is an increase in awareness of male issues because of the existing programs and the media attention they have gotten.	Men, Child & Teen
Population Based Services	II	District II Families FIRST is beginning to engage men and fathers in its work, and the Child Abuse Prevention Program is also expanding to include fathers.	Male & Teen
Population Based Services	II	In Espanola, Las Cumbres Learning Services provides prevention and early intervention services that includes a teen fathers' group.	Teen
Population Based Services	IV	Boys and Girls Clubs use Smart Moves curriculum on making good decisions.	Child & Teen
Infrastructure Building Services	IV	Mesalands College and Eastern New Mexico University with grant from Ford Foundation has an economic development effort through increasing access to education, especially vocational education.	Teen

Table B. Number of Program Capacity Citations for Male Involvement and Fatherhood*

Population Group	Direct				Enabling				Population				Infrastructure			
	District I	District II	District III	District IV	District I	District II	District III	District IV	District I	District II	District III	District IV	District I	District II	District III	District IV
Pregnant Women & Mothers																
Infants																
Children														2		1
CYSHCN																
Teens	1				4	2						1	7	9		3
Males	1				5	2						1	5	6		2
All														1		

Table C. Recommendations on Male Involvement and Fatherhood

Pyramid Level	District	Current Capacity Activities Identified	MCH Population Group
Direct Services	I	Increase access to emergency contraception. *	Male & Teen
Enabling Services	I	Make public health offices more “male-friendly.” *	Male & Teen
Enabling Services	I	Hold a conference for young men to provide training, education, and support.	Male & Teen
Enabling Services	I	Help small business to develop business plans to reach out to employable males.	Male & Teen
Enabling Services	I	Take information and education to where men are (e.g., barbershops, bars)	Male
Enabling Services	I	Overcome barriers to using male language.	Male & Teen
Enabling Services	II	Make public health offices/clinics more “male-friendly” (e.g., add posters with men, magazines for men). *	Male & Teen
Enabling Services	II	Get St. Vincent’s Hospital, Santa Fe to reach out more to males (e.g., prostate screening program, sessions on alcohol abuse prevention).	Male & Teen
Population Based Services	IV	Create breater awareness of the need for programs that focus on males and publicize information on the various programs that involve males. *	Male & Teen
Infrastructure Building Services	I	Provide training for providers in public health offices (clerks, office staff, etc.) to get males into family planning services. *	Male & Teen
Infrastructure Building Services	I	Use an economic cost-effectiveness argument to support male-oriented prevention efforts versus detention centers. *	Male & Teen
Infrastructure Building Services	I	Establish a commission on fatherhood.	Male & Teen
Infrastructure Building Services	I	Explore how to fund male involvement programs and services.	Teen

Table C. Recommendations on Male Involvement and Fatherhood

Pyramid Level	District	Current Capacity Activities Identified	MCH Population Group
Infrastructure Building Services	I	Set up a central clearinghouse to provide information on programs and resources for men and boys.	Male & Teen
Infrastructure Building Services	I	Using the concept of “rites of passage,” develop a strategy to put more emphasis in programs on male needs.	Teen
Infrastructure Building Services	I	Focus on primary prevention for males.	Male & Teen
Infrastructure Building Services	II	Replicate South Valley (Albuquerque) Male Involvement Project. *	Teen
Infrastructure Building Services	II	Develop service learning program in the District II public health offices/clinics to provide the opportunity for youth to learn about public health as a possible career; Title X funds for male involvement could fund stipends for men to do health internships both during the school year and in summer. *	Teen
Infrastructure Building Services	II	Add a requirement to NM Department of Health requests for proposals that respondents describe how they will involve and reach men and potential fathers. *	Male & Teen
Infrastructure Building Services	II	Assign a point person in the NM Department of Health, District II, who will be responsible for addressing male involvement in health programs.	Male & Teen
Infrastructure Building Services	II	Set up a central clearinghouse to provide information on programs/activities for men and boys.	Male, Child & Teen
Infrastructure Building Services	II	Recruit male health promotion staff for the Primeros Pasos program to attract male clients since this program is run by females.	Male & Teen
Infrastructure Building Services	II	Get the Santa Fe Health Planning and Policy Commission to consider male involvement in an upcoming policy review.	Male & Teen

Table C. Recommendations on Male Involvement and Fatherhood

Pyramid Level	District	Current Capacity Activities Identified	MCH Population Group
Infrastructure Building Services	II	Involve faith communities in addressing male involvement through ecumenical efforts.	Male & Teen
Infrastructure Building Services	II	Provide training for athletic coaches on “being a good role model.”	Child & Teen
Infrastructure Building Services	II	Focus on gender reconciliation and not just one gender or the other since the need is to strengthen families.	All
Infrastructure Building Services	IV	Create a central repository and forum for information on male involvement and related programs. *	Male & Teen
Infrastructure Building Services	IV	Replicate existing good models such as the Young Father’s Project and the South Valley (Albuquerque) Male Involvement Project. *	Teen
Infrastructure Building Services	IV	Assign a staff person in the Family Health Bureau as a point person who deals with men’s and boy’s issues.	Male, Child & Teen

Table D. Number of Recommendations on Male Involvement and Fatherhood*

Population Group	Direct				Enabling				Population				Infrastructure			
	District I	District II	District III	District IV	District I	District II	District III	District IV	District I	District II	District III	District IV	District I	District II	District III	District IV
Pregnant Women & Mothers																
Infants																
Children														2		1
CYSHCN																
Teens	1				4	2						1	7	9		3
Males	1				5	2						1	5	6		2
All														1		

II.B.4.6.a-d Obesity

MCH Program Capacity and Related Recommendations

During the MCH Needs Assessment workshops, 50 services were identified related to MCH program capacity and obesity. No direct services were noted; capacity was greatest with respect to infrastructure building (23 citations), followed by enabling (15 citations) and population based services (12 citations). Services were provided to all population groups for the three pyramid levels, with the greatest numbers provided to teens (36), children (35); and pregnant women and mothers (31). Seventeen services each for males and CYSHCN were cited. Five services for infants and two for all population groups were noted. (See Table A, Sheet C6 for a detailed description of program capacity; Table B, Sheet CC6 for a count of program capacity citations; Table C, Sheet R6 for a detailed description of recommendations; and Table D, Sheet RC6 for a count of recommendations.)

Direct Health Care Services

Program capacity was not cited for any of the four districts during the MCH Needs Assessment workshops, but it should be noted that public health offices, community health centers and clinics, and private health care providers may address obesity, nutrition, and physical activity with the MCH population during brief health care visits.

Recommendations were cited only by District I. The one recommendation proposes incorporating discussion of physical activity into WIC and other public health clinic visits. This recommendation would impact pregnant mothers, children, children and youth with special health care needs, teens, and males.

Enabling Services

Program capacity was cited extensively by all four districts. Ten services were identified for children; nine services for pregnant women and mothers; eight for teens; three for males; and one service was noted for all population groups. Enabling services include many innovative nutrition and physical activity education and prevention programs such as “Kids Cook” for latch key children; programs working with cafeteria staff; WIC obesity prevention “mini-grants”; WIC Farmers Market program; a partnership between a community health center and a community recreation center providing free memberships for low income families; fitness incentives at a clinic for immigrant children and families; many different elementary school-based education and physical activity programs, several of which will follow children over several years to measure change; County Extension nutrition programs; and components of CMS to address obesity and nutrition issues for children and youth with special health care needs.

Recommendations were made by all four districts. Twenty-three recommendations were cited. Nine recommendations impact pregnant women and mothers; sixteen affect children; fifteen impact teens; and four impact all populations groups. Districts III and IV recommended incorporating easy physical activity programs into existing school structure and curriculum. Two additional recommendations involve the addition of physical activity and nutrition components to existing community programs and services such as day care, summer programs, after school programs, and youth programs such as Boy/Girl Scouts and 4-H as well as inclusion of more physical activity and nutrition education, including education about healthy portion size and appropriate food choices, in current public health programs and services. Giving incentives to clients, for example pedometers to WIC clients, and incentives donated by community service organizations to school children and youth were recommended. District II recommended implementing a “Walking Bus” program where adult volunteers would walk children to school. Other physical activity and nutrition recommendations include implementing a “parents/families as teachers” program for physical activity and nutrition; having public health be a role model by giving employees exercise time; focusing on low cost programs for family fitness (e.g. walking together); and implementing cooking/nutrition programs for children, teens, and food stamp recipients. Several recommendations encompass financial incentives for physical activity including reduced health insurance rates for fit families and reduction of enrollment fees for lower income children to participate in summer and after school physical activity/sports programs. One recommendation cited would promote drinking water.

Population Based Services

Program capacity was cited by all four districts, with eight of the twelve services cited by District III. Ten services were provided to teens; nine services each were provided to pregnant women and mothers and children and youth with special health care needs; eight services to males; and seven services to children. The statewide program, New Mexico on the Move, has fostered motivational walking programs for people of all ages throughout the state. District III has implemented walking programs in many of its counties and communities for children, young people and adults. The District II Health Officer of the Public Health Division has provided creative leadership in approaches to physical activity and nutrition for public health and school staff as well as other adults in the community. School-based health centers in District IV and other locations provide diabetic screening and counseling for students.

Recommendations (none cited)

Infrastructure Building Services

Program Capacity was cited in all four districts. Twenty-three services were cited. Teens and children were recipients of the most services (18 each); thirteen services were provided to pregnant women and mothers; six each to males and children and youth with special health care needs; five to infants; and one to all population groups. The Office of Physical Activity and Nutrition of the NM Department of Health is developing a state plan to address physical activity and nutrition

issues and needs among all populations groups, including the MCH population. A statewide coalition, NM Action for Healthy Kids, provides statewide leadership for policies in schools and communities that will promote physical activity and nutrition for children and young people. This coalition successfully supported legislation in 2005 to require the Public Education Department to set nutrition standards for competitive foods in schools. New Mexico also has a Governor's Council on Physical Activity and Nutrition. Other Infrastructure Building Services include training for public health staff and, day care workers; data collection efforts through WIC, family planning clinics, Family Support Programs, and the Youth Risk and Resiliency Survey in the schools; and community planning and policies to support physical activity.

Recommendations were cited by all four districts. Sixteen recommendations were made relevant to infrastructure building services and obesity. Five of these impact children; one would benefit children with special health care needs; five would benefit teens; and five would impact all population groups. All districts included recommendations for policies to require daily physical activity/education in the schools and the funding to support such policies; three of the four districts recommended regulations regarding healthy foods in schools – including vending machines, competitive foods, and cafeterias.

Data on obesity is needed, and recommendations were made to code this on the death certificate and on all public health and other health care encounter forms. Community health councils need to be involved in creating friendly community environments for physical activity. Community food banks need to link the food provided to prevention of obesity. Health care providers need education on obesity management and nutrition and facilitation techniques to promote “power with (not “over”)” approach to education. The policy that allowed state employees (including public health staff) time for physical activity needs to be restored. Making water accessible and collaborating with water-related programs (e.g. arsenic removal at the pueblos) was recommended.

Constraints/Barriers were cited by District I, II, and III. Concerns raised included the lack of a “friendly” environment for physical activity in communities; cultural attitudes toward food and obesity and children; bureaucratic constraints when communities want to undertake creative projects; nutritionists not having private provider Medicaid numbers; and Medicaid and other insurance not recognizing obesity as a medical problem; lack of CMS nutritionists and obesity not being a recognized condition under CMS; tendency in schools to address obesity without addressing physical activity; lack of training of classroom teachers at the elementary level in nutrition and physical education and minimal requirements for PE in mid and high school; fast foods and high sugar/fat vending machine foods in schools; lack of social workers and

registered dieticians to take referrals related to obesity and physical activity; and need for child care while parents exercise.

Table A. Program Capacity for Obesity

Pyramid Level	District	Current Capacity by Activities Identified	MCH Population Group
Enabling Services	I	"Kids Cook" is in 10 Albuquerque schools for latch key kids. It involves classroom activities and teaches kids to cook/prepare snacks; also works with cafeteria staff. It has reached 4,000 children over 3 years and is funded by the McCune Foundation, USDA, Healthier Communities grants, and APS in-kind.	Child
Enabling Services	I	WIC gives obesity mini-grants to increase family physical activity and improve nutrition; use clinics. Grants have supported play days for kids and parents and community gardens.	Maternal, Male, Child & Teen
Enabling Services	I	Fit Families in Sandoval County targets families of 2-5 year olds. It will hire a community health worker and will offer cooking classes and food shopping tours, etc.	Maternal, Male, Child & Teen
Enabling Services	I	CATCH program is in Cibola County and APS funded through Chronic Disease Bureau/DOH; the program is for 3 rd – 5 th graders.	Child
Enabling Services	I	The Stanford, Belen and other public health offices have healthy recipes available in waiting rooms and other locations; during Farmers Market season recipes using fresh fruits and vegetables are made available.	Maternal & Teen
Enabling Services	I	Farmer's markets.	Maternal & Teen
Enabling Services	II	CMS and WIC nutrition clinics and services; CMS nutritionist goes to asthma, metabolic and other outreach clinics; separate clinics for overweight children with special health care needs; CMS works closely with WIC for babies with special needs.	CYSHCN
Enabling Services	II	La Familia Medical Center and Chavez Community Center partnership provides free memberships for low income families to the community center's physical activity and recreation services.	Maternal, Male, Child, Teen & CYSHCN
Enabling Services	II	WIC initiative is aimed at reducing juice/sugar drink consumption.	Maternal, Infant, Child & Teen
Enabling Services	II	Villa Therese Clinic serves many immigrants; clinic has implemented changes to addresses physical activity and nutrition – fitness incentives; set scales correctly; document BMI for both well and sick children; follow-up program with 10 children; do sports physicals.	All
Enabling Services	III	In Dona Ana County, the Paso del Norte Foundation gave WIC a grant to add a physical activity component.	Maternal, Child & Teen

Table A. Program Capacity for Obesity

Pyramid Level	District	Current Capacity by Activities Identified	MCH Population Group
Enabling Services	IV	WIC diet assessments.	Maternal, Child & Teen
Enabling Services	IV	In Quay and Guadalupe Counties, second graders are being weighed and measured; physical activity and nutrition intervention; follow-up in fourth grade. This is a project of the Quay County Health Council.	Child
Enabling Services	IV	CATCH (Coordinated Approach to Child Health) is in some Roswell schools beginning in 3 rd grade. A grade is then added each year in participating schools.	Child
Enabling Services	IV	Chaves County Extension Office offers healthy cooking classes using the "Kitchen Creations" curriculum.	Maternal
Population Based Services	I	CMS does nutrition screening for all ages and then referrals to nutritionist for obesity; follow-up is provided.	CYSHCN
Population Based Services	II	District has been working to get adults to be active (no matter what their weight); fitness levels are assessed with simple methods; articles written on physical activity; pedometers given out at School Nurse Update.	Maternal, Male, Teen & CYSHCN
Population Based Services	II	New Mexico on the Move initiative encourages physical activity and healthy eating.	Maternal, Male, Child, Teen & CYSHCN
Population Based Services	III	Motivational walking programs. Paso del Norte Foundation funds Walk El Paso, Walk Otero, Walk Dona Ana – walking clubs, group walks, challenges, etc. Walk Otero involves schools, teachers, and worksites.	Maternal, Male, Child, Teen & CYSHCN
Population Based Services	III	Catron County on the Move – team competition with prizes for adults; 300 pedometers given out (County Health Council bought these); nutrition presentations/mini-seminars.	Maternal, Male, Child, Teen & CYSHCN
Population Based Services	III	Socorro County – partnering with Striders and Riders; 5-10 k walk/run at end of program; County Health Council supporting this; pedometers given out. Want to put program in schools.	Maternal, Male, Teen & CYSHCN

Table A. Program Capacity for Obesity

Pyramid Level	District	Current Capacity by Activities Identified	MCH Population Group
Population Based Services	III	Catron County grocery store (Reserve) will put up nutrition posters (comparative information).	Maternal, Male, Teen & CYSHCN
Population Based Services	III	County Extension – has cooking classes and nutrition education (I Can Program). Catron County does not have an extension office, but it can bring someone in to do this education.	Maternal & Teen
Population Based Services	III	Socorro County – the Boys and Girls Club has a program to teach children to play.	Child
Population Based Services	III	Otero County – in Alamogordo walking paths will connect all parks. The city also has a Walking Ability Group. There is a school nutrition committee replacing soda pop with healthy choices including water and good juices. At youth functions water is being served instead of soda pop.	Maternal, Male, Child, Teen & CYSHCN
Population Based Services	III	Sierra County participated in the America on the Move. Monthly walk for everyone in TorC.	Maternal, Male, Child, Teen & CYSHCN
Population Based Services	IV	Roswell school-based health centers provide diabetic screening and counseling.	Child & Teen
Infrastructure Building Services	I	UNM is conducting a study of mothers and eating habits with WIC in Cuba.	Maternal & Teen
Infrastructure Building Services	I	Sandoval County health office is a participant in a family planning obesity project.	Maternal & Teen
Infrastructure Building Services	I	The Family Support Programs for NM get height and weight for everyone who comes in.	Maternal, Infant, Child, & Teen
Infrastructure Building Services	I	Family Planning/WIC has a collaborative training program around obesity.	Maternal, Infant, Child, & Teen

Table A. Program Capacity for Obesity

Pyramid Level	District	Current Capacity by Activities Identified	MCH Population Group
Infrastructure Building Services	I	Sandoval County is training public staff and families to get personally involved in physical activity.	Maternal, Male, Child & Teen
Infrastructure Building Services	I	Office of Physical Activity and Nutrition (OPAN) is sponsoring a forum in Albuquerque for state obesity plan recommendations.	All
Infrastructure Building Services	II	Action for Healthy Kids providing statewide leadership on nutrition and physical activity policies for children.	Child, Teen & CYSHCN
Infrastructure Building Services	II	WIC trains providers around positive feeding relationships; WIC Conference addressed this issue.	Maternal, Infant, Child & Teen
Infrastructure Building Services	II	County extension provides nutrition classes for day care providers.	Infant & Child
Infrastructure Building Services	II	WIC data base available to identify children with potential overweight problems. BMIs can be calculated from the data.	Child
Infrastructure Building Services	III	School vending policies (sell healthy food and drink products).	Child & Teen
Infrastructure Building Services	III	Bike and walking paths are being established and creating safe and friendly environments for physical activity.	Maternal, Male, Child, Teen & CYSHCN
Infrastructure Building Services	III	Office of Physical Activity and Nutrition (OPAN)/NM Department of Health has a \$500,000 grant to develop a state strategic plan to prevent obesity. Held community meetings to get ideas for plan.	Maternal, Male, Child, Teen & CYSHCN
Infrastructure Building Services	III	Governor's Council on Physical Activity and Nutrition.	Maternal, Male, Child, Teen & CYSHCN

Table A. Program Capacity for Obesity

Pyramid Level	District	Current Capacity by Activities Identified	MCH Population Group
Infrastructure Building Services	III	Action for Healthy Kids – coalition to address physical activity and nutrition for school age kids.	Child & Teen
Infrastructure Building Services	III	WIC serves 0-5 year olds. Staff is trained in healthy feeding relationships.	Infant & Child
Infrastructure Building Services	III	YRRS data available for each county.	Teen
Infrastructure Building Services	III	Las Cruces is developing bike paths.	Maternal, Male, Child, Teen & CYSHCN
Infrastructure Building Services	III	Grant County has a physical activity plan.	Maternal, Male, Child, Teen & CYSHCN
Infrastructure Building Services	III	Las Cruces schools have a new school position for nutrition and physical activity.	Child & Teen
Infrastructure Building Services	IV	Kindergarten BMI statewide pilot project is being conducted in selected sites (including Roswell) by school nurses. Children will be tested again in eighth grade; project includes nutrition and physical activity education and intervention for parents and children.	Maternal & Child
Infrastructure Building Services	IV	Action for Healthy Kids (statewide coalition) is developing a tool kit for schools to use in developing a “Wellness Policy” that addresses nutrition education and physical activity.	Child & Teen
Infrastructure Building Services	IV	Title X obesity pilot project is doing BMIs in family planning clinics.	Maternal & Teen

Table B. Number of Program Capacity Citations for Obesity*

Population Group	Direct				Enabling				Population				Infrastructure			
	District I	District II	District III	District IV	District I	District II	District III	District IV	District I	District II	District III	District IV	District I	District II	District III	District IV
Pregnant Women & Mothers					4	2	1	2		2	7		5	1	5	2
Infants (I)													2	2	1	
Children (C)					4	2	1	3		1	5	1	3	4	9	2
CYSHCN (SN)						2			1	2	6			1	5	
Teen (T)					4	2	1	1		2	7	1	5	2	9	2
Male (M)					2	1				2	6		1		5	

Table C. Recommendations on Obesity

Pyramid Level	District	Recommendations Cited at MCH Needs Assessment Workshops	MCH Population Group
Direct Services	I	Incorporate discussion of physical activity into WIC and other clinic visits	Maternal, Male, Child, Teen & CYSHCN
Enabling Services	I	Work with people on understanding healthy portion size and appropriate food choices through all public health services. *	Maternal, Male, Child & Teen
Enabling Services	I	Encourage drinking water.	All
Enabling Services	I	Give WIC clients pedometers and other incentives for physical activity	Maternal & Teen
Enabling Services	II	Look for opportunities for parents, families to be own (peer) teachers regarding physical activity/nutrition (model program in El Paso). *	Maternal, Male, Child & Teen
Enabling Services	II	Implement a "Walking Bus" program where adult volunteers walk children to school.	Child
Enabling Services	II	Reduce enrollment fees for summer sports programs to allow all children to participate.	Child & Teen
Enabling Services	II	Allow public health and other agency employees exercise time at work so they can be role models for clients.	Maternal, Male, Child, Teen, CYSHCN
Enabling Services	II	Add physical activity components to day care and summer programs.	Child & Teen
Enabling Services	II	Provide positive reinforcement of healthy habits.	All
Enabling Services	II	Provide reduced insurance rates for fit families.	All
Enabling Services	II	Implement fitness testing more widely.	Maternal, Male, Child & Teen

Table C. Recommendations on Obesity

Pyramid Level	District	Recommendations Cited at MCH Needs Assessment Workshops	MCH Population Group
Enabling Services	III	Provide grocery store nutrition education. * (no cost/low cost)	Maternal, Male, Child & Teen
Enabling Services	III	Implement easy daily physical activity in schools (for example, walking daily around the school yard perimeter). * (no cost/low cost)	Child & Teen
Enabling Services	III	Focus on increasing family physical activity (e.g., walking together). * (no cost/low cost)	All
Enabling Services	IV	Educate parents and children about nutrition and physical activity as part of current public health services. (no cost/low cost) *	Maternal, Male, Child, Teen, CYSHCN
Enabling Services	IV	Implement physical activity programs in schools that can be incorporated into existing structure and curricula; e.g. students and teachers walk around the school perimeter once a day, walking contests, walking programs linked to other subjects like geography. (no cost/low cost) *	Child & Teen
Enabling Services	IV	Implement after school programs with qualified instructors and certified programs to address physical activity and nutrition. (cost)	Child & Teen
Enabling Services	IV	Provide summer programs with physical activity components. (cost)	Child & Teen
Enabling Services	IV	Work with Boy/Girl Scouts/4H to add physical activity and nutrition badges/programs. (no cost/low cost)	Child & Teen
Enabling Services	IV	Provide cooking classes for pregnant women and new mothers. (no cost/low cost)	Maternal
Enabling Services	IV	Implement the "I Can" Program (from Quay County), a nutrition program with cooking demonstrations for third graders.	Child
Enabling Services	IV	Implement cooking and nutrition programs for food stamp recipients. (cost)	Maternal, Male, Teen
Enabling Services	IV	Implement Cooking with Kids Program (cost)	Child
Enabling Services	IV	Expand CATCH (Comprehensive Approach to Child Health) to other school districts (cost)	Child

Table C. Recommendations on Obesity

Pyramid Level	District	Recommendations Cited at MCH Needs Assessment Workshops	MCH Population Group
Infrastructure Building Services	I	Create policies and programs to support physical activity including a policy for daily physical activity in schools. *	Child & Teen
Infrastructure Building Services	I	Restore physical activity policy for state employees*	All
Infrastructure Building Services	I	Get community health councils involved in community development, environment issues to create “physical activity friendly” community environments. *	All
Infrastructure Building Services	I	Record obesity on death certificate in order to get data on the severity of the problem in New Mexico. *	All
Infrastructure Building Services	I	Work toward healthier foods in schools (vending machines, cafeterias).	Child & Teen
Infrastructure Building Services	I	Link food bank policies and the food they distribute to obesity prevention.	All
Infrastructure Building Services	I	Make water accessible; collaborate with water-related programs (for example, arsenic removal programs at pueblos).	All
Infrastructure Building Services	I	Record obesity on public health and other health care encounter forms.	Maternal, Male, Child, Teen & CYSHCN
Infrastructure Building Services	I	Increase the number of dieticians available for CMS referrals.	CYSHCN
Infrastructure Building Services	II	Provide daily physical activity opportunities for all children, families. *	All
Infrastructure Building Services	II	Require physical activity at elementary school-level to be integrated into school day. *	Child & Teen

Table C. Recommendations on Obesity

Pyramid Level	District	Recommendations Cited at MCH Needs Assessment Workshops	MCH Population Group
Infrastructure Building Services	II	Lobby year round and align advocates for better physical activity and school nutrition policies.	Child & Teen
Infrastructure Building Services	III	Regulate school food and competitive foods. * (no cost/low cost)	Child & Teen
Infrastructure Building Services	III	Adopt statewide, mandatory school policy by the Public Education Department for daily physical activity and funding. (cost)	Child & Teen
Infrastructure Building Services	IV	Educate nurses, physicians and other providers on obesity management and nutrition as well as facilitation techniques so they can educate in turn using “power with” not “power over” approaches. * (no/low cost)	All
Infrastructure Building Services	IV	Adopt a statewide daily physical activity policy through the Public Education Department and funding to implement it. (higher cost)	Child & Teen

Table D. Number of Recommendations on Obesity

Population Group	Direct				Enabling				Population				Infrastructure			
	District I	District II	District III	District IV	District I	District II	District III	District IV	District I	District II	District III	District IV	District I	District II	District III	District IV
Pregnant Women & Mothers					4	2	1	2		2	7		5	1	5	2
Infants (I)													2	2	1	
Children (C)					4	2	1	3		1	5	1	3	4	9	2
CYSHCN (SN)						2			1	2	6			1	5	
Teen (T)					4	2	1	1		2	7	1	5	2	9	2
Male (M)					2	1				2	6		1		5	

II.B.4.7.a-d Teen Births and Chlamydia

MCH Program Capacity and Related Recommendations

During the MCH Needs Assessment workshops, 21 services were identified related to MCH program capacity and teen births and Chlamydia. The number of services cited by pyramid level was: enabling (13), infrastructure building (5); population based (2), and direct (1). Services were noted for five population groups: teens (21), pregnant women and mothers (5), children (3), infants (1) and males (1). (See Table A, Sheet C7 for a detailed description of program capacity; Table B, Sheet CC7 for a count of program capacity citations; Table C, Sheet R7 for a detailed description of recommendations; and Table D, Sheet RC7 for a count of recommendations.)

Direct Health Care Services

Program capacity was cited only in District II, and this service was provided to teens. While only one district noted school based health centers as a source of clinical service capacity for teen births and Chlamydia, all districts have school based health centers providing at least prevention services, if not direct clinical services. Direct services are also available related to this issue area through public health offices in all districts.

Recommendations were cited only by District IV. The one recommendation impacts pregnant women and mothers, teens, and males. The District recommended that information should be provided to clients in clinic settings on the implications of risky behaviors.

Enabling Services

Program capacity was cited in all four districts. Among all services cited by pyramid level, enabling services were most frequently cited (13 citations). These services are provided to teens (13 citations), children (3), pregnant women and mothers (2), and infants (1). Services include a wide variety of prevention and education programs provided through public health offices, school-based health centers, school classrooms, recreational centers, university-sponsored programs, and faith-based organizations including churches.

Recommendations were cited by all four districts, and 17 recommendations were made. All were relevant to teens; five to males; four to pregnant women and mothers; two to children and youth with special health care needs; and one to children. Four recommendations cited concern education about teen pregnancy prevention for parents and students and emphasized the need to reach young people at an earlier age (6th grade and Middle School). Other recommendations

included increasing the availability of parenting classes through WIC, faith based organizations and other locations and use of the curriculum “Dare to be You”; improving communication about available resources; support for access to comprehensive services for teens, including expansion of school based health center services; increasing involvement of males in education about sexually transmitted diseases and teen pregnancy; support for more recreational activities for teens; providing help to teens who want to become pregnant to plan appropriately; and improving Department of Health contracts to specify how contractors should refer teens to other resources to meet their needs.

Population Based Services

Program capacity was cited by Districts II and IV. Two services were identified for teens and one each for pregnant women and mothers and males. Services include public health office STD screening and health fairs reaching young people.

Recommendations were cited by Districts I, II, and III. All recommendations impact teens; three impact males; and one impacts pregnant women and mothers. Recommendations include expanding on the current momentum for teen pregnancy prevention efforts; supporting social marketing strategies and the NM Media Literacy Project to raise awareness among teens about Chlamydia prevention, screening, and treatment and teen pregnancy prevention; increasing disease prevention efforts through community distribution of condoms; involving males more actively in opportunities for education about STD and teen pregnancy prevention; and educating the population broadly about teen pregnancy and Chlamydia issues including policy makers, parents, and students.

Infrastructure Building Services

Program capacity was cited by all four districts. Services were identified for teens (5); pregnant women and mothers (2); and males (1). Districts II, III and IV recognized the work of community/county health councils that are addressing teen pregnancy prevention as a health planning priority. The work of seven rural community resource centers in District III was cited. The NM Teen Pregnancy Coalition is providing technical assistance to school-based pregnancy prevention projects in three of the four districts.

Recommendations were cited by all four districts. All fifteen recommendations impact teens and two each impact pregnant women and mothers, children, and males. Two recommendations specifically address involving youth more actively in state and community planning and actions regarding teens and teen pregnancy through community health councils, and the NM Forum for Youth in Community. More community collaboration and coordination around these issues are also recommended, including working more

closely with the faith community, Boys and Girls Clubs and other youth oriented programs, and the business community. The need for more funding for a full range of education and prevention programs from abstinence to sexuality education to contraception information is presented. Also noted is the need to use existing resources such as community recreation centers more effectively. The South Valley Male Involvement Project in Albuquerque is recommended as a good prevention model for other districts to implement. District IV recommended developing a “train the trainers” curriculum about how to talk to children about sex inviting community/county health council members to attend this training and then offering free facilitated learning to the public.

Constraints/Barriers were cited by Districts III and IV. Many school districts have significant restrictions for addressing sexuality issues and offering information about pregnancy prevention, especially birth control. Public health staff in one district stated that abstinence-only programs were not based on best public health practice and evidence. More than 60% of NM parents with school-aged children support teaching about birth control by the 7th/8th grades.⁶

Funding for prevention and education services and for school-based health centers is inadequate; some new funding was approved in the 2005 legislative session for new centers, but no new funding for existing centers that are struggling to offer adequate services.

Concern was expressed that only nurse midwives can prescribe for females, thereby creating limited provider resources for this problem. Too few males are being screened for Chlamydia, therefore increasing risks for re-infection of females. **Community Strengths and Resources**, one citation and only in one district. District IV has many strong partners including health councils, Big Brothers and Big Sisters, faith-based groups (e.g., Hope Center).

⁶ New Mexico Teen Pregnancy Coalition, “TUNE-In: New Mexico Attitudes on Sex Education,” 2001.

Table A. Program Capacity for Teen Births and Chlamydia

Pyramid Level	District	Current Capacity by Activities Identified	MCH Population Group
Direct Services	II	School-based Health Centers provide clinical services in junior high and high schools starting at puberty and build trust with teens.	Teen
Enabling Services	I	School-based Health Centers provide services.	Teen
Enabling Services	I	The New Mexico GRADS (Graduation Reality and Dual-Role Skills) is a prevention and intervention program for pregnant and parenting teenagers.	Teen
Enabling Services	I	Abstinence education programs	Child
Enabling Services	I	Strengthening Families Initiative of NMSU conducts parenting classes.	Maternal & Teen
Enabling Services	II	Public health clinics provide education on STDs and teen pregnancy prevention.	Teen
Enabling Services	II	Las Vegas has opened a recreational center for teens where services could be offered.	Teen
Enabling Services	III	Las Cruces Public Schools have parents program, home visits, and education in school; also GRADS and GRADS Dads.	Teen
Enabling Services	IV	School-based Health Centers provide services.	Teen
Enabling Services	IV	Nurse practitioners in family planning clinics provide good “teaching moments” for youth.	Teen
Enabling Services	IV	County health person gives talks in middle school on teen pregnancy.	Teen
Enabling Services	IV	Faith-based community sponsors abstinence education and does training in churches on sex ed and STDs.	Child & Teen
Enabling Services	IV	Clovis schools use “Baby Think it Over” with teens.	Teen
Population Based Services	II	Public health clinics provide screening for STDs.	Maternal & Teen

Table A. Program Capacity for Teen Births and Chlamydia

Pyramid Level	District	Current Capacity by Activities Identified	MCH Population Group
Population Based Services	IV	Health Fairs in Clovis and Roswell held four times a year provide good opportunities to reach youth.	Teen
Infrastructure Building Services	I	NM Teen Pregnancy Coalition's educational and technical assistance to school-based pregnancy prevention projects (e.g., through Planned Parenthood of NM at Ernie Pyle Middle School and South Valley Academy)	Teen
Infrastructure Building Services	II	Community health councils support teen pregnancy prevention.	Teen
Infrastructure Building Services	III	Dofia Ana County is currently trying to blend different councils together.	Maternal & Teen
Infrastructure Building Services	III	Seven rural community resource centers are delivering a program, "Strengthening Families".	Maternal, Male & Teen
Infrastructure Building Services	IV	County health councils are top partners, each working on 2 priorities (access to care, teen pregnancy).	Teen

Table B. Number of Program Capacity Citations for Teen Births and Chlamydia*

Population Group	Direct				Enabling				Population				Infrastructure			
	District I	District II	District III	District IV	District I	District II	District III	District IV	District I	District II	District III	District IV	District I	District II	District III	District IV
Pregnant Women & Mothers					2				1						2	
Infants (I)					1											
Children (C)					2			1								
CYSHCN (SN)																
Teen (T)		1			5	2	1	5	1		1	1	1	1	2	1
Male (M)									1						1	
All (A)																

Table C. Recommendations on Teen Births and Chlamydia

Pyramid Level	District	Recommendations Cited at MCH Needs Assessment Workshops	MCH Population Group
Direct Services	IV	Provide information to clients in clinic settings on the implications of risky behaviors.	Maternal, Male & Teen
Enabling Services	I	Write tighter Department of Health contracts to spell out where and how contractors should refer teens to other community resources. *	Teen
Enabling Services	I	Increase outreach by public health offices and contractors to raise health literacy among youth.	Teen
Enabling Services	I	Improve communication about available resources.	Teen
Enabling Services	I	Get school-based health centers to provide full services.	Teen
Enabling Services	I	Support comprehensive access to services.	Teen
Enabling Services	II	Conduct parenting classes (e.g. through WIC) to educate and empower the participants. *	Maternal, Male & Teen
Enabling Services	II	Educate parents as well as teens on teen pregnancy and birth control.	Maternal, Male & Teen
Enabling Services	II	Support more activities and recreation for teens.	Teen
Enabling Services	III	Coordinate educational efforts such as teen pregnancy prevention.	Teen
Enabling Services	III	Continue raising awareness about family activities, e.g., "Strengthening Families."	Maternal, Male, Child & Teen
Enabling Services	IV	Reach children at an earlier age (6th grade and middle school) to educate them on the range of risky behaviors, promoting healthy lifestyles, and providing prevention education. *	Child & Teen
Enabling Services	IV	Help youth who want to get pregnant to plan ahead and initiate healthy behaviors such as good nutrition and avoid risky behaviors (alcohol, STDs, etc.). *	Teen

Table C. Recommendations on Teen Births and Chlamydia

Pyramid Level	District	Recommendations Cited at MCH Needs Assessment Workshops	MCH Population Group
Enabling Services	IV	Get faith-based community to conduct parenting classes.	Maternal, Male & Teen
Enabling Services	IV	Have more mentoring programs for teens.	Teen
Enabling Services	IV	Implement parenting classes for parents and children such as "Dare to Be You" used in Colorado.	Maternal, Male & Teen
Population Based Services	I	Educate policy makers, parents and students about the issues. *	Maternal, Male & Teen
Population Based Services	I	Increase disease prevention efforts with community distribution of condoms.	Male & Teen
Population Based Services	I	Support social marketing efforts to raise awareness among teens	Teen
Population Based Services	I	Involve Media Literacy Project in raising awareness of Chlamydia.	Maternal, Male & Teen
Population Based Services	II	Involve males more actively in opportunities for education about STD and teen pregnancy prevention. *	Male & Teen
Population Based Services	III	Keep up the momentum of current teen pregnancy prevention efforts and expand. *	Teen
Infrastructure Building Services	I	Increase access to services (extend clinic hours, increase number of service sites especially proximate to teens). *	Maternal, Male & Teen
Infrastructure Building Services	I	Use the mobile health unit more for service delivery teens.	Teen

Table C. Recommendations on Teen Births and Chlamydia

Pyramid Level	District	Recommendations Cited at MCH Needs Assessment Workshops	MCH Population Group
Infrastructure Building Services	I	Involve the NM Forum for Youth in Community in the decision-making process.	Teen
Infrastructure Building Services	I	Support nurse practitioners from public health offices to go to school-based health centers.	Teen
Infrastructure Building Services	II	Get public health staff and health groups in the community to partner with the faith community to address teen pregnancy and STD prevention. *	Teen
Infrastructure Building Services	II	Use the South Valley Male Involvement Project in Albuquerque as a good model for District II.	Teen
Infrastructure Building Services	II	Encourage public health staff to work more with local Boys and Girls Clubs and other youth-oriented programs and to have a greater presence in the schools.	Child & Teen
Infrastructure Building Services	II	Get youth groups and community councils to work together more on teen pregnancy prevention and related teen issues.	Teen
Infrastructure Building Services	III	Bring different entities together to work effectively in a coordinated effort. *	Teen
Infrastructure Building Services	III	Go out into the community and build relationships.	Teen
Infrastructure Building Services	IV	Provide more funding for education programs from ranging from abstinence, sexuality education and contraception. *	Teen
Infrastructure Building Services	IV	Use existing resources more effectively, such as community recreation centers.	Teen

Table C. Recommendations on Teen Births and Chlamydia

Pyramid Level	District	Recommendations Cited at MCH Needs Assessment Workshops	MCH Population Group
Infrastructure Building Services	IV	Approach the business community for support.	Teen
Infrastructure Building Services	IV	Publicize the costs and benefits of prevention vs. services.	Teen
Infrastructure Building Services	IV	Develop a “train the trainers” curriculum about how to talk to children about sex inviting Community/County Health Council members to attend this training and then offering free facilitated learning to the public.	Child & Teen

Table D. Number of Recommendations on Teen Births and Chlamydia*

Population Group	Direct				Enabling				Population				Infrastructure			
	District I	District II	District III	District IV	District I	District II	District III	District IV	District I	District II	District III	District IV	District I	District II	District III	District IV
Pregnant Women & Mothers				1		2	1	2	2				1			1
Infants (I)																
Children (C)							1	2						1		1
CYSHCN (SN)																
Teen (T)				1	5	3	2	5	4	1	1		4	4	2	5
Male (M)				1		2	1	2	3	1			1			1
All (A)																

II.B.4.8.a-d Violence

MCH Program Capacity and Related Recommendations

Thirty-eight services on MCH program capacity and violence were identified during the MCH Needs Assessment workshops. Services cited by pyramid level include infrastructure building (17), enabling (15), population based (5), and direct (1). Services were cited for all population groups except CYSHCN: teens (23 citations); children (20); pregnant women and mothers (14); males (11); infants (5); and all population groups (5). (See Table A, Sheet C8 for a detailed description of program capacity; Table B, Sheet CC8 for a count of program capacity citations; Table C, Sheet R8 for a detailed description of recommendations; and Table D, Sheet RC8 for a count of recommendations.)

Direct Health Care Services

Program capacity was cited only in District II with one service identified impacting pregnant women, teens, and males. Colfax County in this district has a domestic violence program providing treatment for battering as well as legal assistance.

Recommendations (none cited)

Enabling Services

Program capacity was cited in Districts II, III, and IV. Ten services each were provided to children and teens; six to pregnant women and mothers; three to males; and two infants. These services address violence prevention education, parents as teachers programs, outreach, counseling, media literacy, relationship building school curricula, advocacy for abused and neglected children and youth, bullying prevention, shelters, home visiting, and safe houses. These services are provided through schools, crisis centers, shelters, community youth programs, GRADS, promotoras and home visitors.

Recommendations were made by Districts I and II related to enabling services. Five of the six recommendations impact teens; three impact pregnant women and mothers; two impact males; and one impacts all population groups. Recommendations cited are to:

- Support interventions for parents of young children and helping victims and perpetrators with parenting skills.
- Use teen theater to raise awareness about dating violence.
- Develop and distribute a domestic violence evidence collection kit and protocol to help in prosecution of perpetrators.

- Use more widely existing resources such as the video on preventing sexual assault developed by the Impact Personal Safety Program in Santa Fe.
- Add a curriculum component on violence and rape to physical education programs in the schools.

Population Based Services

Program capacity was cited in all four districts. A total of five services were identified. Two services each were provided to teens, males, and all population groups; one service each was provided to pregnant women and mothers, children. These services are delivered through community sites and schools and include a safety parade in Torrance County, health fairs, fatherhood initiatives, and school and community programs on bullying prevention.

Recommendations (none cited)

Infrastructure Building Services

Program capacity was cited in all four districts. A total of seventeen services were identified. Ten services were noted for teens; nine services for children, six services for pregnant women and mothers; five services for males; three services for infants; and three services were provided to all population groups. Several state and local coalitions and community/county health councils collaboratively address violence issues, including the NM Coalition Against Domestic Violence and NM Coalition of Sexual Assault Programs. The legislature through a 2005 Memorial has directed the Department of Health in conjunction with other organizations and agencies to study the status of children exposed to domestic violence. Training in violence prevention is occurring in Districts II, III and IV for students, social workers, promotoras, and others. All districts are reporting programs and services being developed in schools and the community as resources for violence prevention and support for victims.

Recommendations were cited by all four districts; 19 recommendations related to infrastructure building services benefit the following population groups: all population groups (11 citations); teens (10); six each for pregnant women/mothers and children; males (5); and infants (2). The recommendations are to:

- Replicate a model for emergency rooms at a hospital in Boston, MA. (cited by Districts II and IV).
- Set up a statewide surveillance system on dating violence.
- Conduct the Youth Risk and Resiliency Survey (YRRS) in Carlsbad (District IV).

Among several recommendations made on domestic violence were those to:

- Implement a domestic violence shelter certification process as well as certification for domestic violence counselors.
- Add substance and alcohol abuse treatment in domestic violence programs.
- Share more information among state agencies and communities on who is doing what with domestic violence and children criminal law (a model from Alaska was cited).
- Improve coordination between the Children, Youth and Family Department and communities.
- Expand the Sexual Abuse Nurse Examiner (SANE) program to more rural areas and to District IV as a whole (cited by Districts II and IV).

Other recommendations cited at the workshops were to:

- Strengthen the VAST program so all public health offices can do adequate and appropriate screening.
- Create community provider resource lists so people screened can be referred to needed community services.
- Obtain more funding for prevention services and “adolescent-friendly” mental health services.
- Get community/county health councils to focus more attention on violence prevention.
- Increase the awareness of school boards about the relationship between media and violence; and then get schools to adopt violence prevention curricula.

Constraints/Barriers were cited in two of the four districts. A current crisis in Carlsbad (District IV) with youth suicide and suicide attempts was cited as were increases in bullying and violent behaviors in Socorro (District III). Lack of coordination between programs; inadequate numbers of staff to handle child abuse and domestic violence cases; lack of treatment programs, shelters, and crisis centers; and lack of availability of current information and materials were noted. School funds in some areas are being shifted away from prevention, and some schools are seeing a reduction in security guards.

Community Strengths and Resources, cited only in District I: the availability of school health and school mental-health advocates and parent groups to address suicide prevention.

Table A. Program Capacity for Violence

Pyramid Level	District	Current Capacity by Activities Identified	MCH Population Group
Direct Services	II	Colfax County has an active domestic violence prevention program that offers treatment for battering and legal assistance.	Maternal, Male & Teen
Enabling Services	II	Media literacy programs can help raise awareness of the underlying links between violence and the media.	Maternal, Male, Child & Teen
Enabling Services	II	Santa Fe Rape Crisis Center is a good model that supports numerous activities including counseling, victim services, and outreach to local schools.	Maternal & Teen
Enabling Services	II	Los Alamos has developed a list of local resources for victims of violence and violence prevention.	Maternal, Male & Teen
Enabling Services	II	The Girls Inc. of Santa Fe has a media literacy program.	Child & Teen
Enabling Services	III	Comprehensive K-12 relationship building curriculum plus program.	Child & Teen
Enabling Services	III	Parents as teachers program.	Maternal, Male, Child & Teen
Enabling Services	III	GRADS program.	Teen
Enabling Services	III	Promotoras program	All
Enabling Services	III	Rio Grande Valley Court Appointed Special Advocates (CASA) provides trained community volunteers who act as advocates for abused and neglected children and youth in Socorro, Catron, and Sierra Counties; connection with police department.	Child & Teen
Enabling Services	III	Rayes Program: group of teachers and parents created groups for children victims of bullying; also, teachers are learning about hotspots and trying to be present.	Child & Teen
Enabling Services	III	In 2 nd grade, there is a "free the horses program" about being nice to each other, friendships, etc.	Child

Table A. Program Capacity for Violence

Pyramid Level	District	Current Capacity by Activities Identified	MCH Population Group
Enabling Services	III	In 4 th grade, there is a tolerance curriculum.	Child
Enabling Services	IV	Domestic violence shelters.	Maternal, Infant, Child & Teen
Enabling Services	IV	Safe houses for interviews of abused children	Child
Enabling Services	IV	Home visiting programs.	Maternal Infant Child
Population Based Services	I	Safety Parade takes place in Torrance County at Christmas time.	All
Population Based Services	II	Bullying prevention projects in the schools are funded by the Safe and Drug Free Schools program of the Dept. of Education.	Child & Teen
Population Based Services	III	Fatherhood initiatives	Male & Teen
Population Based Services	III	Socorro held community forum on violence and bullying.	Maternal & Male
Population Based Services	IV	Health fairs.	All
Infrastructure Building Services	I	APS- Cibola High School Suicide Prevention Program.	Teen
Infrastructure Building Services	I	Family Fun Fest in Valencia County, which is funded by CYFD.	All

Table A. Program Capacity for Violence

Pyramid Level	District	Current Capacity by Activities Identified	MCH Population Group
Infrastructure Building Services	I	Anti-bullying with peer mediators in elementary schools (Blue Prints)	Child
Infrastructure Building Services	I	John Marshall School has parenting classes.	Maternal, Male? & Teen
Infrastructure Building Services	I	NM Senate Joint Memorial 53 (passed during the 2005 legislative session) on Services for Children Exposed to Violence is funding a study by DOH and its partners on the status of children and exposure to domestic violence. A report will be given to the Health and Human Services Subcommittee in Fall 20005.	Child
Infrastructure Building Services	II	In Taos, efforts to prevent domestic violence provide a good model of cooperation among CYFD, domestic violence prevention advocates, and the Men's Resource Center of Northern New Mexico.	Maternal, Male, Child & Teen
Infrastructure Building Services	II	In Raton, the Public Health Office, school-based health clinics, and the Health Council are working together to deal with suicides in the community and to address suicide prevention. Also, the Colfax Mental Health Center is working with UNM to get a psychiatric resident in Raton.	Teen
Infrastructure Building Services	II	NM Senate Joint Memorial 53 (passed during the 2005 legislative session) on Services for Children Exposed to Violence is funding a study by DOH and its partners on the status of children and exposure to domestic violence. A report will be given to the Health and Human Services Subcommittee in Fall 20005.	Child
Infrastructure Building Services	II	There are two state coalitions (NM Coalition Against Domestic Violence and NM Coalition of Sexual Assault Programs) that are concerned with violence prevention. A new network (called The Network) has been created on both issues for bi-monthly meetings and information exchange. They distribute a monthly "E news" with important announcements and research related to DV and sexual assault.	Maternal, Male, Child & Teen
Infrastructure Building Services	II	District II has a good network of School-based Health Centers.	Child & Teen
Infrastructure Building Services	II	Almost every county has shelters for victims of violence, and Colfax County has a new safe house.	Maternal, Infant, Child & Teen

Table A. Program Capacity for Violence

Pyramid Level	District	Current Capacity by Activities Identified	MCH Population Group
Infrastructure Building Services	II	Las Vegas has a strong domestic violence coalition.	Maternal, Male, Infant, Child & Teen
Infrastructure Building Services	II	In Santa Fe County, the DWI program supports training of "Natural Helpers" in Pojoaque High School. These are students who serve as peer resources to other students who are having problems.	Teen
Infrastructure Building Services	III	Pilot effort to educate social workers about child abuse cases (received additional funding); in June, specialty training for promotoras and training for families begins.	Maternal, Male, Infant, Child & Teen
Infrastructure Building Services	IV	County health council initiatives have increased awareness of violence issues.	All
Infrastructure Building Services	IV	Specialized programs, such as Quay County's combined DV/DWI initiative and Eddy County's train the trainers in bullying prevention	All
Infrastructure Building Services	IV	Surveys	All

Table B. Number of Program Capacity Citations for Violence*

Population Group	Direct				Enabling				Population				Infrastructure			
	District I	District II	District III	District IV	District I	District II	District III	District IV	District I	District II	District III	District IV	District I	District II	District III	District IV
Pregnant Women & Mothers		1				3	1	2			1		1	4	1	
Infants (I)								2						2	1	
Children (C)						2	5	3		1			2	6	1	
CYSHCN (SN)																
Teen (T)		1				4	5	1		1	1		2	7	1	
Male (M)		1				2	1				2		1	3	1	
All (A)									1			1				3

Table C. Recommendations on Violence

Pyramid Level	District	Recommendations Cited at MCH Needs Assessment Workshops	MCH Population Group
Enabling Services	I	Raise awareness in high schools about dating violence using teen theater. *	Teen
Enabling Services	I	Support interventions for parents while their children are still young. *	Maternal, Male, Infant, Child & Teen
Enabling Services	I	Need to determine better ways to help with parenting issues for victims and perpetrators.	Maternal, Male & Teen
Enabling Services	II	Develop and make available a domestic violence evidence collection kit and protocol so that evidence is handled properly and can be used to prosecute perpetrators. *	Maternal, Male & Teen
Enabling Services	II	For schools that have a physical education program, add a curriculum unit on dating violence and rape.	Teen
Enabling Services	II	Use more widely educational video on preventing sexual assault that was developed by the Impact Personal Safety Program in Santa Fe.	Maternal & Teen
Infrastructure Building Services	I	Provide more dollars for prevention. *	All
Infrastructure Building Services	I	Increase information available on what agencies and communities are doing related to domestic violence in the state.	All
Infrastructure Building Services	I	Increase information available about what is happening around counties and domestic violence and children criminal law (Alaska has a good model)	All
Infrastructure Building Services	I	Need to learn how to use retired people and others as volunteers to assist with these activities.	All
Infrastructure Building Services	II	Support more rural based Sexual Abuse Nurse Examiner (SANE) sites. *	All

Table C. Recommendations on Violence

Pyramid Level	District	Recommendations Cited at MCH Needs Assessment Workshops	MCH Population Group
Infrastructure Building Services	II	Strengthen Violence, Alcohol, and Substance Abuse (VAST) programs so that all public health offices can fulfill their screening obligations (by training all providers) and the screening can be linked to community resources by creating a list of resources/responders in the community (as has been done in Los Alamos). *	All
Infrastructure Building Services	II	Increase awareness of school boards about the link between media and violence and promote adoption of violence prevention curriculum in schools. This would involve developing a presentation ('dog and pony" show) on this issue.	Child & Teen
Infrastructure Building Services	II	Assess issue of dating violence in the state.	Teen
Infrastructure Building Services	III	Establish and fund consistent adolescent & family friendly mental health services. *	All
Infrastructure Building Services	III	Establish a domestic violence program that includes substance and alcohol abuse treatment. *	Maternal, Male & Teen
Infrastructure Building Services	III	Improve coordination between Children, Youth and Families Department and local community services/partners (such as home visiting) on child abuse, especially in terms of response to Domestic Violence in families. *	Child & Teen
Infrastructure Building Services	IV	Expand domestic violence shelter services and certification.*	Maternal, Infant, Child & Teen
Infrastructure Building Services	IV	Increase school-based mental health services and access to those services. *	Teen
Infrastructure Building Services	IV	Ensure that county health council or other group has on-going specific focus on violence prevention. *	All
Infrastructure Building Services	IV	Increase certification of people providing Domestic Violence counseling for both victims and perpetrators.	All

Table C. Recommendations on Violence

Pyramid Level	District	Recommendations Cited at MCH Needs Assessment Workshops	MCH Population Group
Infrastructure Building Services	IV	Expand SANE program to District IV.	All
Infrastructure Building Services	IV	Support expansion of suicide prevention activities.	Maternal, Male, Child & Teen
Infrastructure Building Services	IV	Create suicide attempt surveillance.	Maternal, Male, Child & Teen
Infrastructure Building Services	IV	Conduct Youth Risk and Resiliency Survey in Carlsbad.	Teen

Table D. Number of Recommendations on Violence*

Population Group	Direct				Enabling				Population				Infrastructure			
	District I	District II	District III	District IV	District I	District II	District III	District IV	District I	District II	District III	District IV	District I	District II	District III	District IV
Pregnant Women & Mothers					2	2									1	3
Infants (I)					1											1
Children (C)					1									1	1	3
CYSHCN (SN)																
Teen (T)					3	3								1	2	5
Male (M)					2	1									1	2
All (A)													4	2	1	3

II.B.4.9.a-d Unintentional Injury

MCH Program Capacity and Related Recommendations

Thirty-seven services were identified during the Needs Assessment workshops on MCH program capacity and unintentional injury. One direct health care service was noted. capacity was fairly evenly distributed among enabling (13); population based (11); and infrastructure building services (12). The services cited are provided to all population groups: teens and children (14 citations each); pregnant women/and mothers, males and all population groups (11 each); infants (9); and CYSHCN (1). (See Table A, Sheet C9 for a detailed description of program capacity; Table B, Sheet CC9 for a count of program capacity citations; Table C, Sheet R9 for a detailed description of recommendations; and Table D, Sheet RC9 for a count of recommendations.)

Direct Health Care Services

Program capacity was cited only by District I; the one service is relevant to all population groups except infants. Fire Department services to assist heavy people who fall out of bed were identified.

Recommendations (none cited)

Enabling Services

Program capacity was cited in all four Districts. Thirty-seven services were identified for pregnant women/mothers and males (6 each); infants (1); children (2); teens (9); and all population groups (2). Districts identified a wide range of services in school and community settings including parenting programs, community bike-helmet and car-seat programs, counseling and education on appropriate discipline for children, needle exchange programs, home visiting, and teen activity programs.

Recommendations cited by Districts I, III, and IV were seven in total and benefited the following population groups: teens (5); three each for pregnant women/mothers, infants, and children; and males (2). No or low cost recommendations include having school-based health centers include injury prevention education, support for injury prevention, parenting/grand parenting/guardian education (use of a video tape, "How to Parent without Beating Your Kids" was recommended), nutrition, and anger management education in clinics and other community locations. Funding recommendations include getting Medicaid and insurance companies to cover the cost of car seats; seeking sponsorship of a car seat trade-in program; and getting managed care organizations to support prenatal care by paying the Current Procedural Terminology Code (CPT) for "physician group education."

Population Based Services

Program capacity was cited in all districts. A total of eleven services were identified related to population based services. Six services were identified for all population groups; four for children; three for infants; and two each for pregnant women and mothers, teens and males. Services include programs for children, youth, and parents for motor vehicle injury prevention, other unintentional injury prevention, drug and alcohol abuse prevention (needle exchange), and DWI prevention. Some specific examples include car seat clinics; injury prevention done at immunization and flu clinics; health and safety fairs; bike rodeos; public service announcements addressing injury issues; and Fire Department and Emergency Medical Services education and services.

Recommendations were cited by Districts I and IV related to population based services. Both of these impact all population groups. Recommendations include getting support for media messages, including using existing material such as “Man to Man” tape, “Stolen Childhood” tape, and billboards with messages on: back to sleep, prenatal care, preconception care, depression, bullying, gun safety; and using low-cost media strategies such as public service announcements (PSAs) and public interest programming.

Infrastructure Building Services

Program capacity was cited in all four districts and for all population groups. Twelve infrastructure building services were identified. Seven services were identified for children; six services were identified for all population groups; five for infants; three for all population groups; two each for pregnant women and mothers, teens and males; and one for children and youth with special health care needs. A state Safe Kids Coalition and local Safe Kids Coalitions in many counties collaboratively address state and local injury prevention issues related to children and youth. Local Emergency Preparedness Councils and community/county health councils address planning and policy on unintentional injuries. Data on violence, alcohol, and substance abuse is collected through public health offices and PRAMS (plans to ask about car seat use). Hospital policies require newborns to go home in car seats.

Recommendations were cited by Districts I, II, and IV. Of the nine recommendations five impact all populations groups; three each impact infants, children, and teens; one impacts pregnant women and mothers. Three districts made recommendations regarding working together in coalitions including partnering with DWI programs; implementing Safe Kids Coalitions and Coordinators in all counties; and blending together the variety of community coalitions/councils that address injury and other MCH issues. One district recommended targeting unintentional injuries as a major health

concern in each community in the district (and New Mexico). Policy and funding recommendations include requiring helmets and licensing for ATVs, helmets for skate boards users, increased state funding for injury prevention; requiring and funding universal home visiting; providing state funding for car seats and helmets; restoring state funding for healthier communities projects that could address local injury prevention issues.

Constraints/Barriers were cited by Districts I, III, and IV. Included were the lack of Safe Kids coalitions and coordinators in many counties; no focus on unintentional injuries in many areas even though it is the leading cause of children/youth deaths; only \$107,000 in state funding directed currently to unintentional injury prevention; increases in suicide and date rape in some areas; and verbal abuse of children observed in stores and other places.

Community Strengths and Resources, cited only in District 1. These are the District's public health staff and community access to "best practice" information and examples; district and local level Public Health Division staff who practice quality leadership principles and have good facilitation skills to work internally as well as with communities; availability of car seat resources; availability of managed care organization health educators who address many issues including injury prevention; access to a strong emergency preparedness group exercise; good relationships with fire department personnel; and relationship with TCCL.

Table A. Program Capacity for Unintentional Injury

Pyramid Level	District	Current Capacity by Activities Identified	MCH Population Group
Direct Services	I	Fire Dept. will come to house to lift heavy people who fall out of bed.	Maternal, Male, Child, Teen & CYSHCN
Enabling Services	I	Referrals to parenting programs, WIC and Families First, etc.	Maternal Male, & Teen
Enabling Services	I	Free bike helmets, car seats and education on use.	All
Enabling Services	I	John Marshall has parenting classes.	Maternal, Male & Teen
Enabling Services	I	Teens Need Teens program.	Teen
Enabling Services	I	Staff in PHO clinics watches parents disciplining children and gives counseling, education, referrals, and modeling as needed. [Comment: Parenting styles differ by ethnicity. New immigrants exercise detailed loving control and instruction over their children. This is lost as they stay in U.S. longer.]	Maternal, Male & Teen
Enabling Services	I	Referrals to human services are helping abusers more than punishment.	Maternal, Male & Teen
Enabling Services	I	In Albuquerque, free bikes helmets are given through some State source.	Child
Enabling Services	I	Needle exchange programs provide instructions on safe injection techniques.	Maternal, Male & Teen
Enabling Services	II	Traffic Safety Bureau provides funding for injury prevention programs.	All
Enabling Services	III	Home visiting is useful for promoting use of car seats.	Infant & Child
Enabling Services	IV	DWI Councils in each county, staff go into schools- JWICA conducts mock autopsy on effects of alcohol.	Teen

Table A. Program Capacity for Unintentional Injury

Pyramid Level	District	Current Capacity by Activities Identified	MCH Population Group
Enabling Services	IV	Young Parents Education (Jessie Robinson)	Teen
Enabling Services	IV	In Quay County, ASAP Program.	Maternal, Male & Teen
Population Based Services	I	Valencia County has a Victim Impact Panel that DWI drivers must talk to; Police do home visits with no shows; road blocks; Breathalyzers are very popular and can be bought over the counter, but they can malfunction, giving false positives making cars with innocent drivers lock up.	Maternal, Male & Teen
Population Based Services	I	Saturday car seat clinics are held in Gallup and Grants; Public Health Division has held mobile car seat clinics.	Infant & Child
Population Based Services	II	Car seat clinics providing car seats and training on how to use properly; hospitals provide car seats.	Infant & Child
Population Based Services	II	Bike rodeos provide education and helmets and other safety equipment for children; sponsored by Optimist Club.	Child
Population Based Services	II	Public service announcements being used to provide education/information about unintentional injury issues.	All
Population Based Services	II	Safer New Mexico Now provides community education on traffic safety and injury prevention.	All
Population Based Services	II	Fire Department and EMS provide education and services.	All
Population Based Services	III	Car seat program	Infant & Child
Population Based Services	IV	Health and safety fairs; EMS staff attends health fairs, gives demonstrations.	All

Table A. Program Capacity for Unintentional Injury

Pyramid Level	District	Current Capacity by Activities Identified	MCH Population Group
Population Based Services	IV	Fire chief works with health staff on Heads Up-Unintentional Accidents Program	All
Population Based Services	IV	Immunization and flu clinics.	All
Population Based Services	IV	Needle exchange in Clovis, Hobbs, Carlsbad, Roswell, Tucumcari.	Maternal, Male & Teen
Infrastructure Building Services	I	Clients are asked VAST questions by staff at Public Health Office Clinics.	Maternal, Male & Teen
Infrastructure Building Services	I	NM Safe Kids Coalition promotes car seat use.	Infant & Child
Infrastructure Building Services	I	Safety measures used in clinics, e.g., close doors to keep kids from wandering.	Child
Infrastructure Building Services	I	Hospitals require car seats for newborns to go home.	Infant
Infrastructure Building Services	II	Safe Kids coalitions exist in some counties.	Infant & Child
Infrastructure Building Services	III	Safe Kids Coalition	Infant & Child
Infrastructure Building Services	III	Legislation is pending to raise the mandatory age for using car seats to 7 and 60 lbs.	Child

Table A. Program Capacity for Unintentional Injury

Pyramid Level	District	Current Capacity by Activities Identified	MCH Population Group
Infrastructure Building Services	III	There will be a question in the PRAMS survey on use of car seats.	Infant & Child
Infrastructure Building Services	IV	Local police, fire and EMS personnel, and State police have a good collaborative relationship.	All
Infrastructure Building Services	IV	Local Emergency Preparedness Councils	All
Infrastructure Building Services	IV	Hospitals sponsor health fairs, give data, provide funds for fairs, testing	All
Infrastructure Building Services	IV	Suicide prevention coalition	Maternal, Male, Child, Teen & CYSHCN

Table B. Number of Program Capacity Citations for Unintentional Injury*

Population Group	Direct				Enabling				Population				Infrastructure			
	District I	District II	District III	District IV	District I	District II	District III	District IV	District I	District II	District III	District IV	District I	District II	District III	District IV
Pregnant Women & Mothers	1				5			1	1			1	1			1
Infants (I)							1		1	1	1		2	1	2	
Children (C)	1				1		1		1	2	1		2	1	3	1
CYSHCN (SN)	1															1
Teen (T)	1				6			3	1			1	1			1
Male (M)	1				5			1	1			1	1			1
All (A)					1	1				3		3				3

Table C. Recommendations on Unintentional Injury

Pyramid Level	District	Recommendations Cited at MCH Needs Assessment Workshops	MCH Population Group
Enabling Services	I	Get managed care organizations to support prenatal care by paying the Current Procedural Terminology code for "physician group education." *	All
Enabling Services	I	Get school-based health clinics to address and prevent injuries. (no cost/low cost)	Teen
Enabling Services	I	Support education in clinics and outside on parenting, nutrition, and anger management; use parenting education tape: "How to Parent without Beating Your Kids" which gives simple, practical concepts. (no cost/low cost)	Maternal, Male & Teen
Enabling Services	I	Conduct parenting education for new parents in hospitals (include mothers and grandmothers). (no cost/low cost)	Maternal, Male & Teen
Enabling Services	III	Get Medicaid to cover the cost car seats.	Infant & Child
Enabling Services	IV	Involve parents/guardians/grandparents who are raising children. *	Maternal, Male & Teen
Enabling Services	IV	Get insurance companies to provide car seats; work with Safer NM Now and sponsor car-seat trade-in program.	Infant & Child
Population Based Services	I	Get support for media messages, including using existing material such as "Man to Man" tape, "Stolen Childhood" tape, and billboards with messages on: back to sleep, prenatal care, preconception care, depression, bullying, gun safety. *	All
Population Based Services	IV	Increase media coverage at no cost via round table programs, PSAs, KOB-TV.	All
Infrastructure Building Services	I	Foster partnering and coalitions with DWI programs and others. *	All
Infrastructure Building Services	I	Get State to require helmets for skate boards, all-terrain vehicles (ATVs) and licensing for ATVs. (no cost/low cost)	Child & Teen
Infrastructure Building Services	I	Support a bill to provide for universal home visiting to address unintentional injury prevention for infants and young children. (costly)	Maternal, Infant & Child

Table C. Recommendations on Unintentional Injury

Pyramid Level	District	Recommendations Cited at MCH Needs Assessment Workshops	MCH Population Group
Infrastructure Building Services	II	Implement Safe Kids coalitions and coordinators in every county to address unintentional injury issues more fully and consistently. *	Infant, Child & Teen
Infrastructure Building Services	II	Appeal to legislators for increased funding, especially for car seats and helmets. *	Infant, Child & Teen
Infrastructure Building Services	II	Target unintentional injuries as a major health concern in each community in the district (and New Mexico). *	All
Infrastructure Building Services	III	Increase funding for unintentional injury prevention (New Mexico provides only \$107,000 in state funding).	All
Infrastructure Building Services	IV	Fund Healthier Communities projects again. *	All
Infrastructure Building Services	IV	Blend all councils to reduce duplication. *	All

Table D. Number of Recommendations on Unintentional Injury*

Population Group	Direct				Enabling				Population				Infrastructure			
	District I	District II	District III	District IV	District I	District II	District III	District IV	District I	District II	District III	District IV	District I	District II	District III	District IV
Pregnant Women & Mothers					2			1					1			
Infants (I)							1	1					1	2		
Children (C)							1	1					2	2		
CYSHCN (SN)																
Teen (T)					3			1					1	2		
Male (M)					2			1								
All (A)					1				1			1	1	1	1	2

II.B.4.10.a-d Positive Youth Development

MCH Program Capacity and Related Recommendations

Forty enabling services and eight infrastructure building services related to capacity and positive youth development were identified during the MCH District Needs Assessment workshops. Services were provided to all population groups, except males. Forty-six services were to teens; 22 to children; and one each to pregnant women/mothers, infants and CYSHCN. (See Table A, Sheet C10 for a detailed description of program capacity; Table B, Sheet CC10 for a count of program capacity citations; Table C, Sheet R10 for a detailed description of recommendations; and Table D, Sheet RC10 for a count of recommendations.)

Direct Health Care Services (none cited)

Enabling Services

Program capacity was cited by all four districts. Of the 40 services identified 38 were for teens; 20 for children; and one each for pregnant women/mothers and infants. All districts identified a large number and wide variety of programs that provide education, self-esteem building, life skills building, employment and career experiences, mentoring, multi-discipline case management, recreation, music, dance, and other activities that contribute to positive youth development. Many kinds of organizations conduct these programs including schools (including alternative schools), school based health centers, Teens Need Teens and other teen-led groups and councils, correctional and judicial institutions and related organizations, after school programs, recreation and community centers, public health programs and offices, community health centers, police, YWCA, churches, 4-H, Girl Scouts, and Boy Scouts.

Recommendations were cited by Districts II, III, and IV relevant to enabling services. All fifteen impact teens and seven impact children. Almost all of the recommendations involved implementing programs and activities for children and young people that build self-esteem, build skills, are enjoyable, and increase educational and employment opportunities. Included are: supervised activities such as dances, movie nights, “lock-ins”, community/service learning projects, “shadowing” employers, entrepreneurial and apprenticeship programs, after school clubs, mentorship programs with the elderly, art programs in schools, work-study programs, cultural programs, gardening. Other recommendations include finding ways to get children to activities safely (especially for working parents); support for drug and alcohol prevention in outpatient facilities; encouraging more prevention education in the schools; providing support services that address after care evaluation for gang violence prevention.

Population Based Services

Program capacity (none cited)

Recommendations were cited only by District IV. Two recommendations were made. The recommendation to implement a media blitz around positive youth development with quality Public Service Announcements (PSAs) would impact pregnant women and mothers; children, teens, and males. The recommendation to carry out the Red Ribbon Campaign would impact children and teens.

Infrastructure Building Services

Program capacity was cited in all four districts; eight services were identified, all serve teens, and three serve children. All Community and County Health Councils and other community coalitions (e.g. Taos Teen Network and the C.A.R.E.S. Coalition) assess needs and plan for community action and resources. Youth are active members in many councils and coalitions. In District III, Catron County now participates in the Youth Risk and Resiliency Survey (YRRS) to collect data on youth behaviors.

Recommendations, cited by all four districts, were 14 in number. There were 10 recommendations affecting both children and teens; one each for CYSHCN and all population groups. Policy recommendations are to mandate K-12 comprehensive health education in the schools and get the NM legislature to adopt measures on positive youth development. A data recommendation is to increase the number of NM school districts implementing the YRRS (71 of 89 school districts participated in 2003), especially the Albuquerque Public Schools, the largest school district in the state.

Funding recommendations are to seek sustainable funding for youth programs that having an impact, summer programs and to obtain more funding for programs in rural areas. Several recommendations were made to replicate programs and community models that are working well. Models cited include:

- Sandoval County “Commons,” where different kinds of providers are together in one location and can do assessment and early identification of problems; provide seamless service and family support.
- McKinley County Health Alliance, which is addressing issues of racism and health disparities.
- Use of health promotion and community development staff through the Public Health Division districts to work on positive youth development strategies with communities.
- Albuquerque’s South Valley Male Involvement Project.

Several recommendations were made regarding expansion of community involvement and collaboration including engaging the faith community and working with organizations such as Big Brothers/Big Sisters. It was stated that there is a need to balance/negotiate the requirements on the part of public health and other government funded programs for “evidence-based” programs and services and community’s expressed needs and interests. It was recommended that trainings be provided to communities related to “hot topics” and that the implementation of positive youth development programs for CYSHCN be studied.

Constraints/Barriers were cited in Districts II and IV. Constraints included lack of non-academic classes and activities both in school and after school, especially in smaller, rural communities; lack of funding or inadequate/inappropriate use of funding and unwillingness of voters to increase taxes; access to activities because of lack of transportation; too few staff or volunteers to help with programs; lack of mixed age group activities; presence of methamphetamine labs, especially in farming areas; sex, teen pregnancy, drugs, and violence; state government bureaucracy; cultural and psychosocial issues; Children’s Code not user friendly.

Table A. Program Capacity for Positive Youth Development

Pyramid Level	District	Current Capacity by Activities Identified	MCH Population Group
Enabling Services	I	Teens Need Teens program in Torrance County has been operating for 11 years. The program involves adult mentors and after school and summer programs. A teen council determines activities; local merchants give members of program discounts.	Teen
Enabling Services	I	South Valley Male Involvement Project links youth to adults; focus on personal and academic development; hosts a basketball tournament with a requirement to take a course in various risk behaviors; gives theater presentations; does educational sessions in the South Valley and jail. The project's staff goes to Adolescent Detention Centers not only to do pregnancy and STD prevention but also to address other risk behaviors.	Teen
Enabling Services	I	Metropolitan Detention Center is linked to programs on the outside like the South Valley Male Involvement Project.	Teen
Enabling Services	I	Juvenile Detention Center will talk to youth about male involvement, etc.	Teen
Enabling Services	I	Various youth programs use good brochures from DOH/Family Planning Program.	Teen
Enabling Services	I	School-based clinic staffs are aware of the importance of emphasizing youth assets.	Teen
Enabling Services	I	Mentoring programs – Wise Men, Wise Women.	Child & Teen
Enabling Services	I	DWI Teen Council in Estancia; teens set rules if teen has an incident.	Teen
Enabling Services	I	GRADS	Teen
Enabling Services	I	Valencia County has multi-disciplinary team doing case management (police, CYFD, Public Health).	Teen
Enabling Services	I	In Valencia County, Peanut Butter and Jelly and the Corrections Department runs La Entrada, a residential program for women who have been released from the Grants prison, and their children.	Maternal, Infant & Child
Enabling Services	I	MCH Program has two videos: "Man to Man" and "Stolen Childhood."	Child & Teen
Enabling Services	II	After school and summer programs are in many places (21 st Century Learning Center after-school programs in Mora and Las Vegas, Hands Across Cultures Teen Center in Espanola).	Child & Teen

Table A. Program Capacity for Positive Youth Development

Pyramid Level	District	Current Capacity by Activities Identified	MCH Population Group
Enabling Services	II	Organized, supervised extra-curriculum sports and dance programs exist in some communities such as Santa Fe.	Child & Teen
Enabling Services	II	CMS transition program (under CYSHCN) including pilot and mentorship programs at NM School for the Deaf and Highlands University.	CYSHCN
Enabling Services	II	In Santa Fe, teen programs and activities such as Warehouse 21 that provides an alcohol free setting for music bands and theatre.	Teen
Enabling Services	II	In Taos and other counties in Northern New Mexico, the Screening, Brief Intervention, Referral and Treatment Cooperative Agreement Project (SBIRT) has counselors through the Public Health Offices who go into schools to help identify high risk behaviors and provide referrals for counseling.	Child & Teen
Enabling Services	II	Distributive Education Clubs of America (DECA) supports work-study programs for students in the community during the school year and summer.	Teen
Enabling Services	II	In Los Alamos, Restorative Justice Program	Teen
Enabling Services	II	Health Centers of Northern New Mexico	Child & Teen
Enabling Services	II	Future Farmers of America and 4-H groups	Child & Teen
Enabling Services	II	Church and Temple groups	Child & Teen
Enabling Services	III	Creative funding initiatives, e.g. in Luna County, young people can do community service in exchange for uniform costs and other fees associated with participating in youth sports.	Teen
Enabling Services	III	Abstinence program includes goal setting for youth and is implemented in grades 2, 4, 6, 7, and 9. It's been going on for 8 years in Socorro.	Child & Teen
Enabling Services	III	Police Athletic program (PAL) provides after-school and summer activities for boys and girls in Hidalgo.	Child & Teen
Enabling Services	III	In Luna County there is a mentorship program, Los Sabrios, in which school counselors identify students at risk.	Child & Teen
Enabling Services	III	In Luna County there is a bullying prevention program in elementary school and ambassadors for kids in middle and high school.	Child & Teen
Enabling Services	III	In Luna County the YWCA has an after-school program especially for 8 th and 9 th grade students that the county subsidizes, but transportation is a problem; also program for children ages 5-13 which also feeds families.	Child & Teen

Table A. Program Capacity for Positive Youth Development

Pyramid Level	District	Current Capacity by Activities Identified	MCH Population Group
Enabling Services	III	In Catron County there are programs for children and young people including 4-H, rodeos, soccer; Brownies is just starting.	Child & Teen
Enabling Services	III	Catron County has the Los Jovenes Youth Center.	Teen
Enabling Services	III	In Catron County The Way Club is sponsored by the Presbyterian Church.	Teen
Enabling Services	III	In Catron County the State Police do program in schools about drinking and drugs.	Child & Teen
Enabling Services	III	Boxing clubs in Las Cruces.	Teen
Enabling Services	IV	Teen and youth centers, after-school and summer programs	Teen
Enabling Services	IV	Mentoring programs in general such as Big Brothers and Big Sisters	Child & Teen
Enabling Services	IV	Sports, Parks and Recreation programs, youth sports leagues	Child & Teen
Enabling Services	IV	Girl Scouts	Child & Teen
Enabling Services	IV	Alternative schools	Child & Teen
Enabling Services	IV	CASA's mentoring for non-adjudication	Teen
Enabling Services	IV	"Baby Think It Over" dolls for teen pregnancy prevention.	Teen
Infrastructure Building Services	I	Public Health Office pre-clinics: provide good comprehensive questions; identify risk factors; good follow-up.	Teen
Infrastructure Building Services	II	Community collaborations such as the Taos Teen Network that involves students, teachers, and community organizations to provide teens with an on-line meeting place.	Teen

Table A. Program Capacity for Positive Youth Development

Pyramid Level	District	Current Capacity by Activities Identified	MCH Population Group
Infrastructure Building Services	II	Taos C.A.R.E.S. Coalition is an umbrella group that is concerned about behavioral issues including teen pregnancy.	Teen
Infrastructure Building Services	II	Clayton Community Health Council	Child & Teen
Infrastructure Building Services	III	Positive youth development is on the agenda of community health councils in District III (e.g., YRRS presentations to councils and schools).	Child & Teen
Infrastructure Building Services	III	Youth are involved in planning youth activities (e.g., Boot Hill Youth Association in Hidalgo and YWCA's Youth Advisory Board in Luna).	Teen
Infrastructure Building Services	III	In Catron County the schools conducted Youth Risk Resiliency Survey (YRRS) for first time.	Teen
Infrastructure Building Services	IV	Wellness/health councils	Child & Teen

Table B. Number of Program Capacity Citations for Positive Youth Development*

Population Group	Direct				Enabling				Population				Infrastructure			
	District I	District II	District III	District IV	District I	District II	District III	District IV	District I	District II	District III	District IV	District I	District II	District III	District IV
Pregnant Women & Mothers					1											
Infants (I)					1											
Children (C)					2	6	7	4						1	1	1
CYSHCN (SN)						1										
Teen (T)					11	8	11	7					1	3	3	1
Male (M)																
All (A)																

Table C. Recommendations on Positive Youth Development

Pyramid Level	District	Recommendations Cited at MCH Needs Assessment Workshops	MCH Population Group
Enabling Services	II	Have supervised activities: dances, dance lessons, movie night.	Child & Teen
Enabling Services	II	Develop activities that have a "cultural" flavor (e.g., a sustainable gardening program).	Child & Teen
Enabling Services	II	Have "lock-in" activities for grades 8-12 to teach kids how to have fun.	Teen
Enabling Services	II	Have "shadowing" days for youth to get exposure to different work settings and professions and give school credit for participation.	Teen
Enabling Services	II	Support work-study programs for upper-class students and get an underwriter so students can make some money.	Teen
Enabling Services	II	Support community/service learning programs, give class credit and consider making this a school requirement (Santa Fe Public High School has a service learning program).	Teen
Enabling Services	II	Support mentorship programs with elderly: "safe kids + safe seniors."	Child & Teen
Enabling Services	II	Support arts programs in schools.	Child & Teen
Enabling Services	II	Support more after-school activities such as chess clubs, computer clubs, etc.	Teen
Enabling Services	III	Find ways to transport children to activities safely, especially for children of working parents (e.g., in Socorro, parents give rides to other children). *	Child & Teen
Enabling Services	IV	Support drug and alcohol prevention in outpatient facilities.	Teen
Enabling Services	IV	Encourage entrepreneurial and apprenticeship programs/Junior achievement.	Teen
Enabling Services	IV	Engage schools in prevention education. (no cost)	Child & Teen
Enabling Services	IV	Support services related to gang violence prevention that address an after-care evaluation component. (cost)	Teen
Population Based Services	IV	Implement media blitz with well thought out and quality public service announcements (PSAs), etc.	All

Table C. Recommendations on Positive Youth Development

Pyramid Level	District	Recommendations Cited at MCH Needs Assessment Workshops	MCH Population Group
Population Based Services	IV	Carry out Red Ribbon Campaign. (low cost)	Child & Teen
Infrastructure Building Services	I	Expand the South Valley (Albuquerque) Male Involvement project (major cost is health educators) to include more participants and more sites. *	Teen
Infrastructure Building Services	I	Get Albuquerque Public Schools to participate in the Youth Risk and Resiliency Survey. *	Teen
Infrastructure Building Services	I	Learn from and replicate good community models such as the Sandoval County "Commons" where different kinds of providers are together in one location and can do assessment and early identification of problems, provide seamless service, and family support. Another model is the McKinley County Health Alliance which is addressing issues of racism and health disparities.*	All
Infrastructure Building Services	I	Strengthen health promotion, community development cadres in district. Where they are now working in the community it makes a difference (for example, the South Valley Male Involvement Project); work for sustainability and replicability. *	All
Infrastructure Building Services	II	Seek sustainable funding to avoid having grant funds end causing termination of youth programs. *	Child & Teen
Infrastructure Building Services	II	Seek funding for summer programs and develop existing programs. *	Child & Teen
Infrastructure Building Services	II	Expand community involvement in positive youth development. *	Child & Teen
Infrastructure Building Services	III	Address tensions between evidenced-based program and interests in different communities; find ways to negotiate solutions. *	Child & Teen
Infrastructure Building Services	III	Create more programs and provide more funds especially for large rural counties with small populations. *	Child & Teen

Table C. Recommendations on Positive Youth Development

Pyramid Level	District	Recommendations Cited at MCH Needs Assessment Workshops	MCH Population Group
Infrastructure Building Services	III	Look at how Positive Youth Development programs can be adapted for or created for Children and Youth with Special Health Care Needs.	CYSHCN
Infrastructure Building Services	IV	Mandate K-12 comprehensive health education in the schools. *	Child & Teen
Infrastructure Building Services	IV	Involve Big Brothers Big Sisters. (no cost)	Child & Teen
Infrastructure Building Services	IV	Support policy making at legislative level. (no cost)	Child & Teen

Table D. Number of Recommendations on Positive Youth Development*

Pop Group	Direct				Enabling				Population				Infrastructure			
	District I	District II	District III	District IV	District I	District II	District III	District IV	District I	District II	District III	District IV	District I	District II	District III	District IV
Pregnant Women & Mothers																
Infants (I)																
Children (C)					4	1	2				1		3	2	3	
CYSHCN (SN)															1	
Teen (T)					9	1	4				1	2	3	2	3	
Male (M)																
All (A)											1	2				

II.B.4.11 Other Issues Identified by New Mexico Health Districts

These additional issues were put forward by the participants in the MCH District Needs Assessment workshops following the conclusion of the priority issue discussion groups that had identified current service capacity, assets, constraints, and recommendations for each priority issue. The issues noted cover a wide range of topics and concerns including data needs; communication and coordination between partners at state, district and local levels, including the Family Health Bureau; funding for prevention programs and services; funding to improve access to health care and other community services; barriers to access to services; health system changes such as the establishment of behavioral health collaboratives; underlying issues such as hunger; and other MCH topics to be addressed (beyond the ten priorities) such as, pre-term birth prevention, methamphetamine impact on children, community fluoridation.

District I

Several issues around data and information were noted:

- Need information on race and ethnic groups to increase awareness of class issues.
- Look at ethnic disparities in data and target funding.
- Use zip code level data for looking at disparities.
- Relate data to allocation of funds.
- Include annotations in data book to explain trends and changes.
- There should be more frequent communicating and sharing about what the Family Health Bureau, district and local public health and community partners are doing.
- There is need for more coordination to avoid duplication of resources.
- Put a comprehensive program and services directory on Web.
- Be creative to fund prevention
- Funding is needed for the community health workers duola program.
- Need for affordable child care including for public health staff.
- More emphasis should be placed on interpreters services for clients.
- Barriers to teen access to health care including contraception; how to make system work.
- Public health staff felt that comprehensive sexuality education is “best practice” for teen pregnancy prevention and that abstinence only programs have important limitations.

- Risk factors for pre-term births need to be addressed (pre-term births have increased by 20% in New Mexico between 1992 and 2002).
- Early Head Start's mandate to work on male involvement is a good opportunity to address this issue.

District II

- Need to hear more from community partners, but it is difficult for them to get away to attend a meeting away from their communities. In the future it would be helpful to have Family Health Bureau staff visit communities ahead of the general district needs assessment meetings.
- Family Health Bureau should meet more frequently with the districts (in between the every five year needs assessment meetings).
- The Family Health Bureau Epidemiologist is willing to visit District II offices to demonstrate access to data relevant to a variety of Title V programs.
- Language continues to be an obstacle to services since so much health information is only in English.
- Information on and promotion of services is needed so that potential clients know they can get care even if they have no money or health insurance.
- Teen confidentiality in obtaining pregnancy termination services is violated when insurance companies provide notice of benefits provided to parents.
- Vision for dental care in future is to have dental care officer in every county. Currently, Santa Fe has a pilot project that links dental care to maternal care.
- Fluoridation in water has declined, and there is no Department of Health fluoride program manager due to funding cuts.

District III

- Coordination of different programs and services (Children, Youth and Families Department, Human Services Department, etc.).
- Feedback is needed from CYFD and information on training.
- Getting undocumented population through obstacles to care.
- Methamphetamine homes and risk for babies and children
- Men as victims of methamphetamine.
- Suicide prevention, still denial of problem;

- suicide prevention moved to schools (school-based health centers).
- Lack of dental services, especially pediatric dentists and orthodontists
- Post-partum depression services.
- Medicaid/Medicare and grandparents.

District IV

- We need more communication about programs and resources and more networking to reduce duplication of programs. Channels of communication should go beyond TV and radio, but all church bulletins, Thrifty Nickel, etc.
- Numbers versus people: performance based budgeting emphasizes numbers and gives too little attention to serving people.
- Prevention versus treating health problems once they develop: Prevention is based on education and can save resources. The statewide Families FIRST program is an example of a prevention program “success story.”
- Gap between Medicaid and health insurance: We need healthy parents to raise healthy children. We need to help parents with health care needs and perhaps this is more important than spending money on welfare.
- Care of undocumented children: We need a policy that ensures humanitarian concern for all residents and that permits treatment of undocumented children and does not report parents of such children.
- Access to University of New Mexico resources: Some district staff sees UNM resources concentrated along the Rio Grande corridor. Family Health Bureau staff responded that UNM staff does what it can but is stretched very thin.
- The Department of Corrections needs to do a better job of assessment and treatment. Chaves County is trying to deal with differences in criminal versus behavioral and mental health needs.
- Hunger in New Mexico is extensive. The Governor held a Summit on Hunger in 2003 and an End Hunger Task Force continues to work on this issue, but there continue to be many gaps in public awareness of hunger in New Mexico. The Backpack Program is one initiative in Albuquerque and Santa Fe that provides food for children and families.
- Access to Salud (managed care organization) for nutrition services including food for children. Medicaid cut this funding. The issue is currently being considered by the Medicaid Advisory Committee.
- Substance abuse: While treatment has improved, there is still a shortage of beds, etc., and we need to do more educating of public health staff. There will be a reorganization of the NM Department of Health; there will be 17 Behavioral Health Collaboratives organized by judicial districts and \$250 million for behavioral and mental health.
- We need more services and housing for homeless pregnant women. This would be a good partnership with faith-based organizations and perhaps such groups could open up some homes.

- Dental care for children and adults: For serving Medicaid eligible people, the state legislature did increase Medicaid reimbursement rates for dentists so the situation has improved, but there are simply too few dentists. There are no local pediatric dentists. District II has a pilot project in which CMS is coordinating with dentists.

II.B.4.12 Strengths and Limitations of Needs Assessment Methods and Procedures

MCH District Needs Assessment workshops were the major source of district and local public health staff and community partner input to the needs assessment process. At the end of each workshop, an evaluation was done from which were compiled the strengths and limitations listed below.

Strengths as noted by district workshop participants:

- Family Health Bureau staff went to the districts to listen to local needs/concerns
- Networking and sharing of ideas between many different programs and geographic areas; obtained ideas about programs to replicate in community
- Interactive agenda and facilitated working groups
- Diversity of participants from different programs and community groups
- Resources received including MCH Data Book
- Allowed participants to express what they were passionate about with respect to MCH issues and needs as well as their provision of services
- Opportunity to learn about topics/issues beyond those with which participants were familiar

Limitations as noted by district workshop participants:

- Participants could only attend two Priority Topic discussion groups, therefore limiting their input to other Topics
- Community representation was small; one district suggested using a community partner survey or organizing meetings at the community level
- This process takes place only every five years; districts would like to see Family Health Bureau staff more frequently (note that individual program staff do visit the districts, but no comprehensive meetings such as these workshops have been held)

Other strengths of workshop process:

- Helped both districts and Family Health Bureau staff see MCH work more holistically at the local and regional level
- Provided a base for continuing interaction with the districts over the next five years
- Identified specific issues where districts and Family Health Bureau staff can work together in the future

Other Limitations of workshop process:

- No consumer representation
- District and local public health staff representation outweighed community partner representation for most of the workshops.
- The workshops were limited in time and could only address a limited number of topics/issues
- Current MCH activities identified are based on perceptions of individuals attending and not a comprehensive picture
- Not enough time to pursue fully constraints and community strengths and resources related to each recommendation

Lessons Learned and How to Address Limitations in Future Needs Assessment Workshops:

Role of FHB and District Leadership in Organizing the Workshops: In spite of timely and good communications between FHB and District leadership in planning the workshops, time itself was a precious commodity. Even earlier communication with the District leadership and clearer delineation of roles and responsibilities with respect to inviting participants and organizational aspects of the workshops may be helpful. Timing of the workshops needs to be reviewed to take into account weather (winter and early spring are unpredictable) and other meetings and activities occurring that may preclude people attending. Holding the workshops in the fall prior to the application due date should be considered.

Some Districts were more successful than others in recruiting participation from among their local partners in both private and public sectors and who work on MCH related programs and services. District management staff that were responsible for the invitations may need more explanatory material about the workshops to send to community partners as part of the invitation to participate. A process for more frequent communication between District leadership and FHB prior to the workshops around which community partners and consumers have responded to the workshop invitation would also be useful. A way to involve consumers in the needs assessment process needs to be found. Outreach to organizations that represent consumers and families such as the Family Alliance and Parents Reaching Out would be a possible approach. One district suggested that Family Health Bureau staff go to communities to meet with local public health staff and community partners prior to workshops being held. It was also suggested that a written survey be sent to community partners, including consumers, ahead of face to face workshops as a way to get broader input.

Overall FHB and workshop participants felt that the inclusion of district workshops as a major component of the needs assessment process was very valuable both for MCH Block Grant application purposes as well as for strengthening communication and relationships between FHB and partners in the districts. It was also considered very important for promoting ongoing communication and partnering between agencies and organizations within the districts.

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ⁱⁱ Kendrick D, Elkan R, Hewitt M, et al. Does home visiting improve parenting and the quality of the home environment? A systematic review and meta analysis. *ArchDis Child* 2000;82:443-51.

ⁱⁱⁱ Morrow AL, Guerrero ML, Shults J, Calva JJ, Lutter C, et al. Efficacy of home-based peer counselling to promote exclusive breastfeeding: a randomised controlled trial. *Lancet* 1999 Apr 10;353(9160):1226-31. Comment in: *Lancet*. 1999 Jul 10;354(9173):161-2

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^v Olds DL, Henderson CR Jr, Kitzman HJ, Eckenrode JJ, Cole RE, Tatelbaum RC. Prenatal and infancy home visitation by nurses: recent findings. *Future Child* 1999 Spring-Summer;9(1):44-65, 190-1.

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^{viii} NM Youth Risk Resiliency Survey 2003, Survey of health indicators in grades 9-12, NM Department of Health, www.health.state.nm.us.

^{ix} Linda Passmark, Edd Rhoades www.health.state.ok.us/program/hpromo/medj/fjournal.htm

^x the National Fatherhood initiative

^{xi} Compiled from Drennan, M. 1998. New perspectives on men's participation. *Population Reports J* (46). PATH. 1997. Involving men in reproductive health. *Outlook* 14(3): 7. Sexuality Information and Education Council of the United States. Who Cares About Boys? *Action Health: Growing Up*. <http://www.siecus.org/inter/nigeria/acti/grow/grow0002.html> (online cited September 9, 1998); and United Nations Fund for Population Activities